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No. 86-

IN THE

Supreme Court of the United States

OCTOBER TERM, 1986

WILLIAM BACKLUND,

Appellant,

v.

THE BOARD OF COMMISSIONERS OF KING COUNTY HOSPITAL DISTRICT NO. 2,

Appellee.

On Appeal From The Supreme Court Of Washington

JURISDICTIONAL STATEMENT

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February 5, 1987

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QUESTIONS PRESENTED

1. Whether a public hospital regulation requiring physicians to carry malpractice insurance was, as applied to a surgeon whose religion prohibited him from complying, invalid under the Free Exercise Clause of the First Amendment where a strict scrutiny of the interests served by the by-law and the alternatives available to serve those interests showed that:

a. The by-law was enacted against the recommendation of the hospital's administration, which had conducted a factual study concluding that the by-law would serve no significant financial or operational need or satisfy any legal obligation of the hospital;

b. The Executive Committee of the hospital's medical staff found no need for the requirement;

c. The physician's patients knew he did not carry malpractice insurance and elected to be treated by him nevertheless;

d. The Board of Commissioners which enacted the by-law would have exempted the physician if he had shown that carrying the coverage created a financial hardship for him;

e. No statute, judicial decision or medical regulation of the State required physicians to carry such insurance, nor did any such state-wide legal authority require public hospitals to enact such a requirement;

f. There were several measures which the Board or the State could have adopted—one of which was enacted before the State Supreme Court acted in this case—which could have responded to the hospital's institutional interests without requiring the physician to violate his religious precepts.

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2. Whether the insurance requirement as applied to the appellant physician and his patients violates the rights of privacy and association of those patients by denying them treatment by the physician of their choice.

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JURISDICTIONAL STATEMENT

William Backlund appeals from the final judgment of the Supreme Court of Washington, dated September 11, 1986 holding that By-Law VIII.1.B of the By-Laws of King County Hospital District No. 2 is not in violation of the First and Fourteenth Amendments to the United States Constitution as applied to appellant.

OPINIONS BELOW

The opinion of the Supreme Court of Washington, 106 Wn.2d 632, 724 P.2d 981 (1986) is reprinted at p. 54a, *infra*. The relevant orders of the Superior Court for King County, the Honorable Robert M. Elston, and respondent's Findings of Fact, Conclusions of Law and Decision are not reported, but are printed at pp. 32a and 22a, *infra*, respectively.

BASIS OF JURISDICTION

The judgment of the Supreme Court of Washington reversing the decision of the Superior Court of King County and reinstating the decision of the Board of Commissioners suspending the privileges of William Backlund, M.D. was entered on September 11, 1986. The Notice of Appeal to this Court was timely filed in the Supreme Court of Washington on November 25, 1986. An extension of 60 days to docket an appeal in this Court on or before February 8, 1987 was granted by Associate Justice Sandra D. O'Connor on November 28, 1986, p. 3a, *infra*. Jurisdiction is invoked under 28 U.S.C. Section 1257(2).

CONSTITUTIONAL PROVISIONS, APPLICABLE STATUTES AND REGULATIONS

First Amendment, United States Constitution:

Congress shall make no law respecting an establishment of religion or prohibiting the free exercise thereof . . .

Fourteenth Amendment, United States Constitution:

. . . nor shall any state deprive any person of life, liberty or property, without due process of law . . .

By-Laws, King County Hospital District No. 2: Article VIII.1.B.

> B. The commission shall require each physician and AHP requesting privileges to practice at Evergreen General Hospital to show evidence at time of initial appointment and annually thereafter that he carries professional liability insurance in amounts considered adequate by the commission. The commission shall establish minimum coverage limits by specialty for the next calendar year annually at its July meeting. Failure of any medical staff member or AHP to maintain established minimum liability coverages shall result in suspension of his privileges as provided in Paragraph F below.

HOW THE FEDERAL QUESTION WAS RAISED

The proceedings below consisted of hearings before the Joint Conference Committee of Evergreen General Hospital and the respondent Board of Commissioners of King County Hospital District No. 2, a trial in Superior Court for King County, Washington and an appeal to the Washington Supreme Court. In each of these proceedings the validity of By-Law VIII.1.B of King County Hospital District No. 2 was challenged under the First Amendment as incorporated by the Fourteenth Amendment of the United States Constitution. The decisions of the Washington Supreme Court, the King County Superior Court and the respondent Board of Commissioners address the validity of the by-law under the free exercise clause of the First Amendment at pp. 28a, 50a, 54a, *infra*. Analysis of those issues necessarily requires resolution of questions regarding associational and privacy rights of appellant's patients.

STATEMENT OF THE CASE

OVERVIEW

Bill Backlund is a physician whose religious convictions prevent him from carrying malpractice insurance. His beliefs were well known to his patients, his colleagues and the public hospital at which he had privileges beginning in 1976. In 1983, the hospital's publicly elected Board of Commissioners enacted a by-law requiring physicians who used the hospital to carry malpractice insurance. The by-law was adopted against the recommendations of the hospital administration which had done a study showing that because of the hospital's special insurance coverage it would serve no significant hospital interest to require such insurance. The Executive Committee of the hospital's medical staff also voted against adopting the requirement.

Dr. Backlund declined to carry the insurance and challenged the by-law as applied to him at hearings before a committee of the hospital and the Board of Commissioners itself. The Board refused to grant a religious exemption, although it would have granted an exemption if he had shown that the insurance was a financial hardship. Dr. Backlund's privileges at the hospital were suspended indefinitely.

The Superior Court reversed and ordered Dr. Backlund's privileges reinstated to the extent necessary for him to treat his own patients at the hospital. The Court found that Dr. Backlund's position was based on bona fide religious grounds. It concluded that in light of the hospital administration's study and its own scrutiny of the Commissioners' findings the Commissioners had failed to satisfy their burden of showing a compelling state interest or that their requirement was the least restrictive alternative for achieving the interests urged.

The State Supreme Court reversed holding that although Appellant's position was based on bona fide religious be-

liefs the Board had met the compelling-state-interest and least-restrictive-alternative requirements. The Court's opinion did not mention or discuss the hospital administration study and report and the fact that the administration and medical staff Executive Committee recommended against adopting the by-law. Nor did it analyze the factual basis for the purported public interests served by the by-law as it applied to Appellant. The Court also dismissed, apparently as irrelevant, the fact that the patients of Appellant wished to have him as their doctor even though he was not covered by malpractice insurance.

STATEMENT OF FACTS

A. Dr. Backlund's Religious Convictions and His Religiously Oriented Medical Practice

William Backlund, an orthopedic surgeon, opened his practice in 1976 in Redmond, Washington, a small city in the Seattle metropolitan area.

In 1974, in Dr. Backlund's words,

> . . . after a great deal of heart searching and realization that I didn't have much purpose in my life I realized through friends that the important thing in life is to have a relationship with the Lord, and at that time I made an act of my will to give over the control of my life to the Lord, Jesus, and . . . to the Bible . . .

RP 199. Since 1974 the Bible has guided the conduct of his everyday life including his medical practice, RP 199, pp. 4a-7a, *infra*, which, he has written, "was founded on prayer and God's Word and will be run in the same manner daily." App. p. 4a, *infra*.

Neither Washington law nor the regulations of the State Medical Board require physicians to carry professional liability insurance. When Dr. Backlund opened his practice, he consulted the Bible for guidance on the question and

determined that such insurance was inconsistent with principles of responsibility for one's actions.

> . . . I knew I was supposed to live my life according to how the Spirit and the Bible reads, so I took a piece of paper and drew out pros and cons and read through the Book of Psalms, Book of Proverbs and Testament, writing down Scriptures that might have some bearing on the principles relating to malpractice insurance. [sic]
>
> . . . .
>
> When I got through with that basically all the Scriptures that I found were opposed to having it, and I could find nothing that was in favor of it and I didn't expect that, but that is the way it happened. And I did that twice; and with that basis, maybe a little fear and trepidation being a new Christian, I made that decision to not carry malpractice insurance . . . in my faith in God I made that decision and I have been blessed since that time.

RP 200-201. Dr. Backlund's study of the Bible also influenced other areas of his medical practice.

> I don't have a collection agency. I believe that is not scriptural. I don't believe I am to force people to pay. Therefore I do not have a collection agency. I believe I need to also exercise the practice of communication and care and concern for individuals which I think is called love in the Scriptures, and basically with that in mind I have chosen to also limit the number of patients I would see so I would be able to communicate and express my concern to them.

RP 201.

From 1976 when he opened his practice until the present, Dr. Backlund has given every new patient the brochure reproduced at p. 4a, *infra*. It reads in part:

> . . . I am a born-again Christian physician whose major objectives are to serve God and my patients to the best of my ability. My desire is to please both in this practice through the application of Christian principles . . .
>
> *I have elected not to be covered by malpractice insurance. Instead my insurance is in the Lord and your trust in me. As a benefit to you, my fees will be lowered accordingly. Also I will make all efforts to keep you realistically informed as to your illness or injury so that your trust and confidence in me will be maintained. Another unique aspect of my practice concerns your obligation as a patient to me. In order to continue my practice my financial obligations must be met. I will place my trust in you to fulfill your obligation to me concerning payments due. Because of my trust, I do not intend to make use of a collection agency. I do not seek wealth; rather I seek your health. But without your financial support, my practice will not continue.* [Emphasis in original.]
>
> . . . . I trust in the Lord that you will find my fees reasonable and fair, and my medical treatment consistent with your expectations, and that you will readily fulfill your obligation to me so I may continue my healing ministry.
>
> . . . .
>
> . . . . I am always open to suggestions as to how to make our relationship better and will be glad to talk with you at any time after office hours on the matter. I will also be privileged to

> counsel you on the matter of your relationship to God and to tell you how he has influenced my life if you so desire. Let these relationships grow in mutual respect and love.

A physician cannot practice his profession fully unless he is given "privileges" at a hospital—that is, the right to use the hospital's facilities to treat his patients. When a physician is granted privileges, even though he remains an independent contractor, he becomes a member of the hospital's medical staff. When Dr. Backlund opened his practice, he sought privileges at Evergreen General Hospital, the hospital nearest to his practice.

He told the hospital Administrator of his religious objection to malpractice insurance and learned that Evergreen did not require it. Evergreen granted him privileges as did Overlake Hospital in Bellevue, Washington.

Dr. Backlund was described by Evergreen in 1983 as

> an active member of this medical community, including serving as the first Chairman of the Hospital's Quality Assurance Program. There are no questions about his competence nor to the best of the hospital's knowledge has a suit ever been filed against him. His decision to not carry liability insurance is based on his religious beliefs, and at least a portion of his patients subscribe to his values.

Dr. Backlund also declined to carry life, health and disability insurance or insurance on his personally owned automobile. However when he purchased his house and leased a car for business he acceded to the insurance requirements of the lender and lessor, respectively. That insurance, Dr. Backlund has testified, is not important in his religious scheme, because "it did not deal with people and relationships."

He believes that to carry malpractice insurance would be a sin and that "I have to obey God before I obey man-made laws." When Overlake Hospital adopted a malpractice insurance requirement he did not comply and lost his privileges.

B. Evergreen Hospital and Its Adoption of a Professional Liability Insurance Requirement

King County Public Hospital District No. 2 is a municipality of the State of Washington created to own and operate Evergreen General Hospital. The Hospital District is governed by an elected commission of five lay persons called the Board of Commissioners or "the Commission." *See* Revised Code of Washington (RCW) 70.44.040.

The hospital is operated by an administrator. Matters respecting the care of patients in the hospital are determined by the medical staff and its director. The Board of Commissioners, which ordinarily meets every four weeks, has ultimate review over the appointment of the administrator and medical staff and of their actions. There is also a Joint Conference Committee (the "Committee") which consists of two Commissioners, two members of the medical staff and the hospital administrator. This Committee reviews proposals from the medical staff, makes recommendations to the Board, and conducts hearings on charges brought against physicians.

In July 1982, at a Committee meeting the commissioner members asked the Administrator to study the possibility of requiring physicians using the hospital to carry malpractice insurance.* In August, the question was referred to the Executive Committee of the medical staff. On September 16, 1982 that Committee unanimously recommended against such a requirement at that time. The Board

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* The genesis of the malpractice insurance requirement is reflected in Minutes introduced by the Board below, the relevant portions of which are set forth in the Appendix, p. 14a et seq.

disregarded the physicians' recommendation and referred the issue for reconsideration to the Joint Conference Committee.

On February 18, 1983, the administration issued a Joint Conference Committee Discussion Paper, reproduced at p. 8a, *infra*. The report concluded:

> *Financially*, our situation is unlike some other areas of the country. In states where hospitals are primarily self-insured or participate in experience rated liability programs, hospitals have been able to save premium dollars and/or settlement pay-outs by requiring their medical staff to share in the liability burden by carrying malpractice insurance.
>
> Due to the way our liability coverage is structured, there is no financial reason for Evergreen to require our medical staff to carry malpractice coverage.
>
> *Legally*, there appears to be no legal obligation or authority for the hospital to assure either its patients or the community at large that the members of its medical staff have malpractice coverage.
>
> *Practically*, establishing a malpractice requirement could embroil us in a suit with our "bare" physician. This individual is a well respected, longstanding member of the medical staff who probably can marshall considerable support from patients and members of the community who agree with or will defend his right to maintain his religious convictions on this issue.

The major reason for considering a malpractice coverage requirement, according to the report, was that the hospital might be sued for an injury involving an uninsured physician and would be viewed as the deep pocket. Evergreen

might then have to pay damages and legal costs it could have avoided if the physician were insured. The administration pointed out, however, that the hospital's insurance carrier would cover these expenses and the hospital's only concern therefore would be as to the effect on its future premiums.

The administration's paper emphasized that: (1) Evergreen obtained its base insurance from the Washington Hospital Liability Insurance Fund of which 74 hospitals in the State of Washington were members; (2) only 50 percent of these hospitals require physicians to carry malpractice insurance; and (3) neither the Fund nor Evergreen's excess insurance carrier would reduce the premium or provide assurance that premiums would not be increased in the future if the malpractice insurance requirement were adopted.

The paper reported that Evergreen had $1,000,000 base and $10,000,000 excess insurance and stressed that this coverage was "community, not experience rated." This meant that the amount of Evergreen's premium depended upon the claims experience of all 74 hospitals in the WHLIF and to only a limited and highly diluted extent upon the claims experience of Evergreen itself. According to the report the practical effect was that there could be no short-term effect on premiums and the long-term effect would depend entirely on the future claims experience of all the hospitals, which could not be predicted.

The minutes of the Board's meeting which followed the Committee meeting state that

> Comm. Ellingson reported the Joint Conference Committee met this evening to review the issue of whether the Board should require physicians to carry malpractice insurance as a condition of medical staff membership at Evergreen. Managment's report indicated there would be no reduction in the hospital's premium to WHLIF if

the hospital requires malpractice insurance; however some of the Committee members felt that in the long run there may be an increase in premiums if losses are incurred. She said if the Board requires malpractice insurance it would be a policy decision as the Board does not have the legal obligation to require it. She indicated another alternative which would lessen the risk of "deep pocket" would be to remove uninsured physicians from the doctor's referral system and Emergency Department backup call schedules.

Managment staff's recommendation to the Joint Conference Committee was not to pursue implementation of a malpractice coverage requirement at this time and to recommend that the WHLIF make mandatory malpractice coverage requirements a condition of all hospital's participation in WHLIF.

Comm. Ellingson reported a motion was made to require mandatory malpractice insurance as a condition of medical staff membership with levels of $100,000/$300,000, but there was not a consensus on the motion.

On April 26, 1983 the Board adopted a mandatory malpractice requirement by amending Article VIII of its By-Laws. No reasons are reported for this action. The Board subsequently required that coverage be in the amounts of $100,000 per occurrence and $300,000 in the aggregate for the period July 1, 1983 through December 31, 1983 and $1,000,000 per occurrence with no minimum aggregate as of January 1, 1984.

PROCEEDINGS BELOW

Dr. Backlund declined to be insured and a hearing was held before the Joint Conference Committee on July 21, 1983. Testimony in support of the by-law was given by

the hospital administration which, upon questioning from a commissioner, agreed that the insurance requirement might hold down the costs of Evergreen's carriers and thereby prevent higher premium increases in the future. The administration admitted, however, that it still believed in the soundness of its original recommendation and that research had uncovered no evidence that hospitals in the WHLIF who required insurance of their physicians had saved any premiums by doing so. Dr. Backlund testified as to the background of his opposition to malpractice insurance.

The Committee found him in violation of the by-law, but declined to recommend his suspension, and recommended that he be given a *de novo* hearing before the Board.

A. The Hearing Before the Board

The hearing before the Board of Commissioners was held on December 8, 1983.

The hospital's counsel contended that the hearing should be confined to determining whether Dr. Backlund had in fact complied with the new by-law and if he had not, if he could offer any "extenuating circumstances"—such as inability to obtain insurance—to excuse the failure. RP 84, 86.

The Board, however, refused to restrict the scope of the hearing and evidence was given as to the basis of the by-law by the administrator, the assistant administrator and an insurance defense attorney. The administrator's testimony, in summary, was as follows:

1. Because Dr. Backlund was on the hospital referral list and the emergency room on-call list, some of the patients he treated were introduced or referred to him by the hospital. Such patients, if injured in the course of treatment, might hold the hospital responsible. A portion of those patients treated in the emergency room might not be aware that Dr. Backlund did not carry malpractice

insurance so that, unlike his regular patients, they would not have the choice of going to an insured physician.

2. Even though the physician is an independent contractor, he or she often works closely with hospital employees and an injured patient will accordingly hold the hospital as well as the physician accountable.

3. Some physicians are concerned about working with uninsured physicians because they feel that if they are joined in a lawsuit the insured physician will be at greater financial risk than would otherwise be the case.

4. A physician who might be inclined to practice defensively might practice even more defensively if he is not covered by insurance, or if he is working with someone who is not covered by insurance.

On cross-examination, the administrator admitted that: (1) it was his belief that an insurance requirement need not be adopted, (2) the WHLIF had still not adopted such a requirement, (3) he was aware of no "instance where a physician had refused to work with Dr. Backlund," RP 116, and (4) "defensive medicine is practiced even when physicians have . . . liability insurance," RP 127, is not "more than what is required," and only involves ordering more tests than might otherwise be ordered. The assistant administrator testified that hospitals without insurance requirements did not report a concern over insured and uninsured health care providers interacting with each other. RP 146-147.

The insurance defense attorney testified that plaintiffs' attorneys will emphasize the liability of insured parties when one or more defendants are uninsured, that at that time Washington law permitted recovery of all damages against either of two jointly liable defendants even when one was only 5% responsible for the injury, and that the practical effect was that the party with insurance was going to pay the full amount of the judgment because he

would not be able to recover over against the uninsured defendant unless he had substantial personal assets.

The attorney testified further that the presence of an uninsured health provider in a lawsuit makes it more difficult to settle a case and the proceeds that go to the plaintiff are likely to come from the carrier of the insured party. In addition, he said, an insured party may have higher defense costs because the uninsured party may not be able to afford a substantial defense.

Dr. Backlund described his religious beliefs, acknowledged that there were other hospitals to which he could move which did not require malpractice insurance, but stated that none were close enough to his practice to properly service his patients.

The Board's deliberations and oral decision were reported. RP 261 et seq. Individual Commissioners commented that there was no constitutional issue because Dr. Backlund could practice in another hospital; that he apparently could afford to purchase the insurance, RP 270; that he was inconsistent but sincere, *ibid.;* that they could not agree with Dr. Backlund's religious convictions, RP 267; that there was concern about whether exemptions could be available for a religious belief which was not a tenet of an established religion. RP 263-264.

The Board suspended Dr. Backlund's privileges and adopted Findings of Fact and Conclusions of Law on December 12, 1983. Among its findings were the following:

— that "Dr. Backlund has shown no financial hardship nor inability to procure the required professional liability insurance in the amount of $100,000 per incident, and $300,000 aggregate."

— that it is "recognized" if a patient is injured by a physician within the hospital, the hospital, as well as the physician likely will be sued, that if the physician is uninsured, the claimant would likely "pursue the hospital for

full financial responsibility," that the hospital "may" be compelled to exert greater administrative and staff effort in defending itself because the physician does not have an insurance defense, that because under Washington law in 1983 each joint tortfeasor was responsible for the entire injury, the hospital could be held for a greater share of the financial burden than its degree of liability would otherwise require.

The Board also found that settlement negotiations may be more difficult and "potentially more costly" and that defensive medicine "may" occur when a physician is uninsured.

The findings acknowledged that the Fund would bear the increased litigation costs that might occur and that any detriment to the hospital "might be difficult to quantify," but concluded that such detriment "clearly exists" and that "patients and/or taxpayers of the District may have to bear additional costs" because a physician is uninsured.

The Board also made findings about Dr. Backlund's religious convictions. Finding No. 37 was to the effect

> that Dr. Backlund appears to be sincere in his beliefs and appears to have held them for sometime.

But it also found that the tenets or dogma of Dr. Backlund's faith do not require him to refrain from purchasing professional liability insurance, his pastor attempted to convince him to procure the insurance, his conviction regarding professional liability insurance appears "to be a unique position professed to be held solely by himself," and appears to be inconsistent because he does have insurance on his home and a leased car.

The Board also concluded that the insurance requirement does not "unreasonably interfere with Dr. Backlund's religious conviction" because he could go elsewhere and

"he is free to purchase professional liability insurance and have his suspended privileges at Evergreen reinstated."

B. The Superior Court Reverses the Board's Decision

Dr. Backlund appealed the Board's decision to the Superior Court for King County which held the by-law unconstitutional as applied to Dr. Backlund.

The trial court remarked, *inter alia* that

> . . . some of the findings of the Board of Commissioners [as to the interest served by the by-law] are more in the nature of opinions or speculations than Findings of Fact based upon evidence.
>
> . . . .
>
> My finding after reviewing the record very carefully is that the evidence firmly establishes that Dr. Backlund's refusal to comply with the requirement for professional liability insurance was because of his sincerely held religious beliefs. I really do not feel that any other reasonable conclusion is possible under the evidence.
>
> . . . It is clear this is not a belief that has been lately developed.
>
> It began early if not at the beginning of Dr. Backlund's practice. It has been followed uniformly since that time. It has not been an uncommunicated belief but has been communicated to patients, prospective patients, associates, physicians, hospital Boards, directors, administrators and all those who might be affected by it.

The trial court reviewed the evidence and findings on which the Board purported to base the by-law and found that they did not establish compelling interests under the standards of free exercise law. Nor did he believe the

Board had met its burden of exhausting the reasonable alternatives that might be available to accommodate Dr. Backlund's belief. The trial court ordered reinstatement of Dr. Backlund's privileges, but, by subsequent order, restricted those privileges to admitting and treating his own patients at the hospital, leaving the hospital free to remove him from its referral or emergency on-call list. Dr. Backlund acceded to these limitations and did not appeal.

C. The Decision of the Supreme Court of Washington

The Board of Commissioners appealed to the Supreme Court of Washington, which reversed.

That Court upheld the trial court's conclusion "that Dr. Backlund's beliefs are sincere . . . [and] warrant first amendment protection." It also acknowledged that since "Dr. Backlund's beliefs are protected by the free exercise clause of the First Amendment, the burden of proof shifts to the Board to prove that (1) a compelling governmental interest justifies the regulation in question and (2) the regulation is the least restrictive imposition on the *practice* of his belief to satisfy that interest."

The Supreme Court recited the various reasons for the by-law reflected in the testimony before and findings of the Board and declared these to be compelling state interests. It also identified as a compelling interest—although it was not reflected in the testimony or findings—a general duty that the hospital owed patients to see that there was a fund to cover injuries even when the hospital was not involved. Washington does not have a statute or regulation imposing such a duty.

The State Supreme Court did not mention or discuss the Discussion Paper and study, the administration's conclusion that no financial benefit would be achieved by requiring malpractice insurance of physicians, and the trial court's opinion. Nor did it address the reasons the trial court determined that the purported justifications for the

requirement, although rationally related to a legitimate legislative goal, did not meet the higher standards of strict scrutiny that apply to challenges under the free exercise clause. The Supreme Court in addition pointed out that under a recent piece of Washington legislation, several of the concerns mentioned in the testimony and findings of the Board had either been eliminated or mitigated because the hospital and its carrier could not in most instances be held for damages caused by a joint tortfeasor. RCW 4.22.070.

The Washington Supreme Court concluded that Dr. Backlund had freely chosen to enter the profession, that his religious practice was a "voluntarily imposed personal limitation" and for this reason could not "override the regulatory scheme which binds others in that activity."

THE SUBSTANTIALITY OF THE FEDERAL QUESTIONS PRESENTED BY THIS APPEAL

A. INTRODUCTION

1. The Federal Question Is Substantial Because the By-Law Concededly Burdened Protected Federal Rights and Whether the Purported Justifications Can Withstand Strict Scrutiny Is Highly Debatable

This country was settled by refugees from religious persecution and this Court has accordingly forbidden officials to cruelly make people choose between the commands of their God and the regulations of government—unless those officials in fact have no alternative. Thus, government may not burden religious conduct unless it can show that the interests served are real, concrete and powerful, and can be served by no other means. *Thomas v. Review Board,* 450 U.S. 707, 101 S.Ct. 1424, 67 L.Ed.2d 624 (1981); *Wisconsin v. Yoder,* 406 U.S. 205, 92 S.Ct. 1526, 32 L.Ed.2d 15, (1972); *Sherbert v. Verner,* 374 U.S. 398, 83 S.Ct. 1790, 10 L.Ed.2d (1963).

> **Only those interests of the *highest order* . . . can overbalance legitimate claims to the free exercise of religion.** [Emphasis supplied].

Wisconsin v. Yoder, 406 U.S. at 215.

> **. . . only the gravest abuses *endangering paramount interests* give occasion for permissible limitations.** [Emphasis supplied.]

Sherbert v. Verner, 374 U.S. at 406. *United States v. Lee*, 455 U.S. 252, 102 S.Ct. 1051, 71 L.Ed.2d 127 (1982) (the limitation must be "*essential* to accomplish an *overriding* governmental interest.") (Emphasis supplied.)

The courts below—the trial court which ruled for, and the State Supreme Court which ruled against, him—acknowledged that Dr. Backlund's conduct was religious, was burdened by the by-law and was constitutionally protected absent a compelling state need which could not be otherwise satisfied. Those courts recognized that, as this Court said in *Thomas*, the uniqueness and even inconsistency of a religious belief does not deprive the believer of the right to hold and act upon it as long as the belief is held in good faith. 450 U.S. at 714-716.

The courts below thus found that Dr. Backlund was exercising protected federal rights. By definition, then, his appeal presents a federal question of substance, unless the justifications urged for suppressing those federal rights are so clear and compelling that there can be no reasonable debate as to their merit.

Even the limited record before the Court shows that this is not the case. For this Court, then, to affirm the judgment below without full briefing and oral argument and without reviewing the complete record would be to renege on the commitment to strict scrutiny expressed repeatedly in the emphatic declarations of the *Sherbert*, *Yoder*, *Thomas* and *Lee* cases.

2. **This Appeal Also Presents Substantial Doctrinal Questions As to the Scope of the Sherbert and Thomas Cases, the Meaning of "Compelling State Interest" In the Free Exercise Context and the Right of a Patient to Choose a Physician**

Dr. Backlund's appeal involves not only the question of whether he has been denied the protections promised by this Court in the landmark cases cited, but also several additional questions of federal cognizance which arise because of the language and methodology of the State Supreme Court's opinion.

1. Does the doctrine of *Sherbert v. Verner* and *Thomas v. Review Board*, arising out of the denial of unemployment benefits, apply equally to the denial of public facilities to one who needs those facilities to pursue his occupation?

2. If analysis will show, as Dr. Backlund contends, that the only concrete "interest" protected by the Hospital District's action is an interest in protecting Dr. Backlund's patients from themselves, is that type of interest sufficient to deprive Dr. Backlund of his free exercise rights and his patients of their associational and privacy rights?

3. If the practice of a person's religious belief affects third persons, is that enough, as the State Supreme Court declared, to justify its prohibition by a governmental body? Does the fact that third parties are affected necessarily establish that a compelling state interest exists?

B. THE WASHINGTON SUPREME COURT'S FAILURE TO STRICTLY SCRUTINIZE AND THE FAILURE OF THE BOARD TO ESTABLISH THAT APPLYING ITS BY-LAW TO DR. BACKLUND SERVED COMPELLING INTERESTS THAT COULD BE SERVED NO OTHER WAY

A statute challenged because as applied it infringes the free exercise clause cannot be saved by showing that it generally furthers a compelling state interest. There must be a compelling interest to support the statute not only

as generally applied, but also in its specific application to the one whose freedom it burdens. *Thomas v. Review Board,* 450 U.S. 707, 718-719 (1981). There must be a compelling interest for denying an exemption. *Id* at 719. Thus, this Court in *Thomas* conceded that there was a compelling interest to support a law which restricted unemployment benefits only to employees for whom work was unavailable. The harm to this interest from exempting persons whose religion prevented them from working, however, was not great enough to justify denying those people an exemption. *Ibid.*

The State Supreme Court did not apply this individualized compelling-state-interest test. It never asked whether an exemption for the one or two people with a religious excuse would have any significant impact on the interests urged in support of the malpractice insurance by-law. It is questionable, indeed, whether it even applied the more generalized test. Its opinion takes the interests urged by the Board at face value, without analysis, and overlooks every significant objection to the Board's action. Those objections included:

First, the hospital administration, the people who actually run the hospital day-to-day, did the only factual study on the question and determined that the requirement was not needed to protect the hospital's finances or assets, nor to meet any of its other obligations. The Executive Committee of the medical staff was in accord. The requirement was imposed from above by the Board, not in response to a need perceived by the administration or the doctors, but by a group of part-time elected officials that had its own agenda.

Second, no state wide authority—the legislature, the courts, the medical board, or the hospital fund—required physicians to carry such insurance. And, indeed, half of the hospitals in the Fund did not have the requirement. The absence of such requirements suggests that the state

as a whole—as opposed to the locally elected hospital board—does not find the interest in such a requirement compelling and that instead the state interest is in permitting freedom of choice.

Third, the Board would have exempted Dr. Backlund from the requirement if it had been a financial hardship for him. But if a doctor's financial limitation can overcome the "compelling" interests served by the by-law, can the Board constitutionally say that a religious restraint cannot? The discrimination suggests that the Board was not sensitive to the importance of free exercise values in the constitutional scheme.

Fourth, the Board offered several reasons for its by-law that cannot be fully refuted in a jurisdiction statement, but even a limited review suggests that they will not withstand strict scrutiny.

1. **Protection of the Hospital's Assets**

a. **Speculativeness of the Interest**

The central argument urged by the Commissioners in their deliberations and hearings was that the by-law was necessary to protect the hospital's assets, because both the hospital and the uninsured physician would probably be sued if that physician's patient were injured at the hospital and the hospital would incur costs it might have avoided if the physician had been insured.

But these putative costs, even if incurred, would not, except to a limited and speculative extent, be paid by the hospital. They would be paid by the hospital's insurance carrier. The hospital's only financial concern would be that if the carrier had to pay too much this might ultimately increase premiums. That would be a speculative concern, however, because the premium depends upon the experience of all hospitals in the Insurance Fund. Indeed, when it enacted the by-law, there remained more than thirty-five hospitals in the fund that did not have the insurance

requirement. If Dr. Backlund had moved to one of those facilities he would have posed *exactly the same concern to Evergreen* as he did when he was on its staff, since Evergreen's premiums were as much a function of the claims experience of the other hospitals as of its own. By itself, then, the Board's action was futile.

Moreover, the fact that those hospitals—and the Fund itself—did not adopt a malpractice insurance requirement suggests that the requirement could not have been considered a major factor in holding down costs or premiums.

The Board offered no evidence that exempting physicians who have a religious ground for remaining uninsured would be likely to increase the premiums of the entire insurance pool to which Evergreen belonged. There is no reason to believe that any significant number of physicians would be exempted on this ground and that the one or two who were would pose a significant risk of substantially higher premiums for the pool.

The administration indicated that orthopedic surgery claims average $30,000 and that there is one chance in 2,000 that a physician will have such a claim made against him. It also acknowledged that no claim had ever been made against Dr. Backlund. There was no evidence that Dr. Backlund could not respond personally to a judgement for $30,000 nor that it was a significant likelihood that he would ever have to respond legally for anything done at the hospital.

b. **Less Restrictive Alternatives.**

Finally, there were less restrictive alternatives available to protect the hospital's assets. First, the hospital could have increased its own insurance by the amount it wished to require of Dr. Backlund and charged him for the additional premium. Dr. Backlund could have paid this because he would not be paying for insurance on himself, but only for an increased cost that he had caused the hospital.

Second, the hospital could have imposed a requirement on Dr. Backlund that he pay for any future premium increases created by his decision not to be covered. If these did in fact occur and were significant, such costs could be determined either by agreement or arbitration.

Third, the State could have—as it virtually did prior to the State Supreme Court's decision—enacted a law holding a joint tortfeasor only liable for that percentage of an injury which corresponded to that tort feasor's fault. Thus, if the hospital was only 5% negligent it would be held for only 5% not 100% of the damages, as the Commissioners purported to fear. The fact that such a law now does exist undermines most if not all of the Commissioners' claims of compelling state interest in this case.

2. Concern of Insured Physicians About Practicing With Uninsured Physicians

The Board contended that other physicians in the hospital were uneasy about practicing with an uninsured physician because if both were sued, the insured physician might be the deep pocket. There is no evidence, however, that any physician at Evergreen General Hospital complained about working with Dr. Backlund, nor that it was necessary for Dr. Backlund to work with physicians who did not want to practice with him, nor that Dr. Backlund's presence on the staff of Evergreen had in the seven years he had been there caused any problem with other physicians who had the right to use the hospital. The fact that the physicians in the hospital did not themselves view the need for malpractice insurance as critical is reflected by the medical staff Executive Committee's refusal to recommend a malpractice insurance requirement and the abstentions of the medical members of the Joint Conference Committee from voting upon the issue.

3. Defensive Medicine

Similarly, the claim that an uninsured physician is likely to practice defensive medicine "as are physicians who work

with him," although hypothetically possible, is not borne out by record evidence and is highly speculative. Indeed, it is not clear that defensive medicine is bad. The hospital administrator testified on behalf of the Board's position that it was a matter of degree; that defensive medicine might be practiced by a person who was covered by insurance as well as one who wasn't, depending on his concern about being sued.

4. The State Supreme Court's Decision Was Based on "Colorable," Not *Compelling* Interests.

Examination of the Board's Findings of Fact reveals a collection of "mays," "mights" and "coulds" which betray the speculativeness of, and the lack of factual support for, the purported interests the insurance by-law supposedly served. The State Supreme Court, by accepting these findings without probing their factual basis, allowed the Board to found its decision on "colorable" not *compelling* interests.

C. IS THE PUTATIVE INTEREST IN ASSURING DR. BACKLUND'S PATIENTS THAT HE WILL BE COVERED BY INSURANCE—EVEN THOUGH THEY HAVE FREELY AND KNOWINGLY CHOSEN HIM AS THEIR DOCTOR—A COMPELLING INTEREST OF THE STATE WHICH CAN JUSTIFY APPLYING THE INSURANCE BY-LAW TO DR. BACKLUND?

1. The Board's Argument that the Hospital Has a General Duty to Dr. Backlund's Patients, Even When Its Own Interests are Not Afffected

The State Supreme Court seemed most impressed by an argument urged by the Board in its brief, although not raised in defense of the by-law in its hearing, in its deliberations or in its findings. The argument was that the hospital had a "duty" to see that patients of physicians using the hospital were provided an assured fund for the payment of claims even when the hospital was not sued or implicated and even when the hospital's economic and

operational interests were not affected. In other words, irrespective of the hospital district's interest *qua* hospital district, the hospital could enforce a general social interest in protecting patients from their physicians.

To say that the hospital has a duty to these patients is to beg the question. There was certainly no legal duty; no Washington statute or case requires hospitals to impose an insurance requirement on physicians. There is no authority of any kind that suggests a patient could look to the hospital—if the hospital was not otherwise liable—if a physician did not have insurance to cover a claim. The State Supreme Court buys the Board's argument and cites a case called *Pedroza v. Bryant*, 101 Wn.2d 226, 677 P.2d 166 (1984), a case decided after the by-law was enacted and after Dr. Backlund's privileges were suspended. *Pedroza*, however, does not impose a duty on hospitals to see that the patients of staff physicians have an assured fund to pay damages caused by those physicians. *Pedroza* says only that the hospital has a nondelegable duty to patients treated at the hospital to see that the physicians it permits to use the hospital are competent and capable of performing the medical services for which the hospital has given them privileges. *Pedroza* makes the hospital itself liable for a physician's negligence on hospital premises if the hospital erred in granting that physician privileges. *Pedroza* gives the hospital reason to take out malpractice insurance itself, to pay for any claims based on the duties declared by *Pedroza*, but says nothing about a duty to see that a physician using it facilities is covered by malpractice insurance in order to protect his patients. Many hospitals in Washington do not require malpractice insurance of their staff physicians and the Washington Supreme Court is not saying these hospitals are in violation of any legal rule.

What the State Supreme Court seems to be saying in fact is that it believes physicians should carry malpractice insurance and therefore it will approve the Board's decision to require it—irrespective of whether there has been

a showing that the hospital has a compelling interest as a hospital to make such a requirement. To be sure, if the state legislature had imposed the requirement, as an expression of its general power to further the welfare of its citizens, the Supreme Court would be on more solid ground. But a local hospital board cannot take unto itself the power to say that an interest is a compelling state interest in the absence of general legislative authority or a showing that the interest is one which it has been empowered by the legislature to define and address. It is only interests recognized as compelling by the State—either directly or indirectly—which can justify a restriction on religious freedom. The hospital district has not been given authority to say what those interests are except as they relate to the running of a hospital. RCW 70.44.

The Supreme Court's decision is not completely clear. It may be saying only that the hospital has a duty to see that a physician who treats patients of other physicians or patients referred to him or her by the hospital—either from its physician referral list or from its emergency room on-call list—should be covered by insurance. That position would be based on the fact that the hospital in effect has held the doctor out to these other patients, who may well have assumed he or she has insurance. But none of this applies to Dr. Backlund. Under the trial court's decision, Dr. Backlund may use hospital facilities only for his own patients, those who know he is not covered by malpractice insurance and nevertheless freely request him as their physician.

2. **There Is a Substantial Question Whether the Freedom of Dr. Backlund and His Patients Can be Infringed on Solely Paternalistic Grounds, And This Interference Raises Freedom of Association and Right of Privacy, As Well as Freedom of Religion, Questions.**

Dr. Backlund's patients know that he carries no professional liability insurance, but freely choose to bear the risks

of his decision because they prefer him over other health care providers.

If it is true, as the hospital administration concluded and the Superior Court found, that there is no financial, economic or operational need that justifies infringing Dr. Backlund's religious freedom, then the only remaining interest the hospital can claim to be compelling is some interest in protecting Dr. Backlund's patients against themselves.

There is no evidence that those patients, if they chose, could not find other ways to insure themselves against an accident arising from their treatment by Dr. Backlund or that their religious convictions are not such that they wish to bear the same risks as does Dr. Backlund, for the same spiritual reason.

But be that as it may, the effect of this regulation, because it prevents their doctor from practicing medicine, is that they must go to someone else, someone who may not create the atmosphere of trust and concern or inspire the confidence that they enjoy in their relationship with Dr. Backlund. The Hospital District thus steps between doctor and patient, one of life's extremely intimate relationships, on the ground that it knows what is best for the patient. See *Roe v. Wade*, 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973); *Griswold v. Connecticut*, 381 U.S. 479, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965); *Brotherhood of Railroad Trainmen v. Virginia*, 377 U.S. 1, 84 S.Ct. 1113, 12 L.Ed.2d 89 (1964). The result is to infringe not only the freedom of religion of Dr. Backlund and the patients who share his beliefs, but also the rights of association and privacy of those patients.

Such paternalistic interests may provide a legitimate ground for economic and welfare legislation against a claim that substantive due process has been denied. But it is another thing to say that a paternalistic concern of this type constitutes such a compelling state interest that it

can override the free exercise of religion. *See Wisconsin v. Yoder, supra,* 406 U.S. 215 (1971). This is especially so when it is not the state as a whole, but only a locally elected hospital board that asserts the interest. If the state believes it has an interest in protecting patients against themselves in this situation, this should be expressed by legislation, not by a hospital district by-law.

Even where the State has affirmatively adopted a paternalistic motive to justify its infringement of free exercise, this Court has been unwilling to accept such a justification. In *Wisconsin v. Yoder, supra,* 406 U.S. at 222-225, 232-234, the state sought to support a requirement of compulsory education to age 16 by invoking its interest in protecting the children and parents from depriving themselves of the benefits of two or three years of high school. This Court held the interest insufficient to justify infringement on the defendants' religious freedom. *Ibid.*

Whether the protection against their will of fully informed adults who have freely chosen their doctor is an interest of the State which will justify infringement of religious conduct—not to speak of associational and privacy interests—is a substantial federal question which this Court should address.

CONCLUSION

This Court has jurisdiction of this appeal and should order full briefing and oral argument to resolve the substantial federal questions it presents.

Respectfully submitted,

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APPENDIX

APPENDIX A

THE SUPREME COURT OF THE STATE OF WASHINGTON

NO. 50634-5

(King County Superior Court Case No. 83-2-17152-11

WILLIAM BACKLUND,

Respondent,

v.

THE BOARD OF COMMISSIONERS OF KING COUNTY HOSPITAL DISTRICT NO. 2,

Appellant.

NOTICE OF APPEAL TO THE SUPREME COURT OF THE UNITED STATES

Notice is hereby given that William Backlund, the Respondent above-named, appeals to the Supreme Court of the United States from the final judgment of the Supreme Court of the State of Washington entered in this action on September 11, 1986, and reversing the trial court's judgment ordering Appellant to reinstate Respondent's hospital privileges and reinstating the Appellant's decision suspending Respondent's hospital privileges.

This Appeal is taken pursuant to 28 U.S.C. Section 1257(2).

/s/ NATHAN JAMES NEIMAN
Nathan James Neiman
Attorney for Respondent

THE SUPREME COURT OF
THE STATE OF WASHINGTON

NO. 50634-5

(King County Superior Court Case No. 83-2-17152-1)

WILLIAM BACKLUND,

Respondent,

v.

THE BOARD OF COMMISSIONERS OF KING COUNTY HOSPITAL DISTRICT NO. 2,

Appellant.

CERTIFICATE OF SERVICE

I, Nathan James Neiman, am counsel for Respondent William Backlund, and am over the age of 21 years. On November 24, 1986, I served the Notice of Appeal to the Supreme Court of the United States in the above-entitled action upon Appellant, Board of Commissioners of King County Hospital District No. 2, by depositing a copy thereof in the first class United States Mail, postage prepaid, and addressed as follows: Philip Carter and David Smith, 1313 Market Street, P.O. Box L, Kirkland, WA 98033.

I further certify that all parties required to be served have been served.

DATED this 24th day of November, 1986.

/s/ NATHAN JAMES NEIMAN
Nathan James Neiman
Attorney for Respondent

APPENDIX B

SUPREME COURT OF THE UNITED STATES

No. A-413

WILLIAM BACKLUND,

Applicant,

v.

BOARD OF COMMISSIONERS OF KING COUNTY HOSPITAL

ORDER

UPON CONSIDERATION of the application of counsel for the applicant,

IT IS ORDERED that the time for docketing an appeal in the above-entitled cause be, and the same is hereby, extended to and including February 8, 1987.

/s/ SANDRA D. O'CONNOR
Associate Justice of the Supreme
Court of the United States

Dated this 28th
day of November, 1986.

APPENDIX C

[Brochure Distributed to Dr. Backlund's Patients]

NOTICE TO MY PATIENTS

As your doctor, I would like to explain my philosophy towards medicine and the history behind this practice. Since it is unique, I feel it is important for you to know. I am a born-again Christian physician whose major objectives are to serve God and my patients to the best of my ability. My desire is to please both in this practice through the application of Christian principles. To that end, certain aspects of my practice are different from the usual and will be discussed fully in this pamphlet. This practice was founded on prayer and God's Word, and will be run in the same manner daily. I have been blessed with healing skills and abilities which the Lord intends for me to use.....for your benefit and for His Glory. And in these endeavors, I will not compromise.

With these thoughts as background, it will be easier for you to understand the unique aspects of my practice; those which set it apart from tradition. *I have elected not to be covered by malpractice insurance. Instead, my insurance is in the Lord and in your trust in me. As a benefit to you, my fees will be lower accordingly. Also, I will make all efforts to keep you realistically informed as to your illness or injury so that your trust and confidence in me will be maintained. Another unique aspect of my practice concerns your obligation as a patient to me. In order to continue my practice, my financial obligations must be met. I will place my trust in you to fulfill your obligation to me concerning payments due. Because of my trust, I do not intend to make use of a collection agency. I do not seek wealth; rather I seek your health. But without your financial support, my practice will not continue.*

As your physician, I will strive to give you the best medical care that is available with your physical, economic

and social interests clearly in mind. I shall try at all times to communicate with you and answer all of your questions. Please feel free to ask questions on all aspects of your medical management, including fees. It is perfectly within your right to know about your diagnosis, treatment and charges, and I encourage your questions or differences of opinion on these matters. I want to treat you as a partner in our relationship. And as partners, we must fully understand and cooperate with each other. Inability to communicate leads to bitterness which is not conducive to a healthy doctor-patient relationship.

As far as my fees are concerned, they have been set commensurate with the service rendered. There are separate fees for initial examinations, follow-up office visits, consultations, house calls, casts, splints, X-rays, injections and surgical procedures. A complete fee schedule is available from the receptionist for your examination. I will be pleased to discuss with you beforehand the cost of any treatments or tests if you so desire. I would prefer payment by cash or check in the office upon leaving; but if this is not convenient, we will bill you at the end of the month. I trust in the Lord that you will find my fees reasonable and fair, and my medical treatment consistent with your expectations, and that you will readily fulfill your obligation to me so that I may continue my healing ministry.

My appointment policy is that there will be a maximum of four appointments per hour. This will allow me adequate time to discuss your case and any other matters fully with you. I would appreciate your notification within 24 hours if you are unable to keep an appointment so that time might be used by someone else in need. My office, in turn, will attempt to keep you informed if I am called away for an emergency and am unable to keep my appointment with you. If you should be over 30 minutes late for an appointment, we will do our best to fit you into the schedule or will give you another appointment. Appointments should

be made no more than two (2) months in advance. I will be pleased to make a house call or meet you at the hospital emergency room or meet you at my office for emergencies, depending upon the nature of the problem. Such a decision (as to location) will need to be based on a telephone conversation with me either at the office or through my telephone exchange during non-office hours. My office hours will be 9:00 A.M.—5:00 P.M. (Mondays, Wednesdays and Fridays).

Non-emergency clinical advice and prescriptions will be handled over the telephone either by myself or by my medical assistant after conferring with me. Such matters will be handled as expeditiously as possible in conjunction with other office matters of the day. Upon specific request, I will return telephone calls at the end of the working day unless an emergency is involved. Then my response will be immediate.

My primary hospital is with *EVERGREEN GENERAL HOSPITAL* in Kirkland, where I am also on emergency call on the hospital call system (for those patients without an orthopedist). I am also affiliated with *OVERLAKE MEMORIAL HOSPITAL* in Bellevue. And I am available for care of nursing home patients at the nearby facilities.

This pamphlet has been written to you to highlight some of my particular policies and philosophies in this medical practice. If you have any questions on these or other matters, please ask. I sincerely hope that you will find our relationship to be a secure and comfortable one with reciprocal enjoyment and satisfaction. I am always open to suggestions as to how to make our relationship better and will be glad to talk with you at any time after office hours on the matter. I will also be privileged to counsel you on the matter of your relationship to God and to tell you how

He has influenced my life if you so desire. Let these relationships grow in mutual respect and love.

.....*W. Backlund, M.D.*

Day or night ----885-6141

APPENDIX D

Evergreen General Hospital
MEDICAL STAFF LIABILITY COVERAGE
JOINT CONFERENCE COMMITTEE DISCUSSION PAPER

2/18/83

ISSUE

Should the Board of Commissioners of King County Public Hospital District #2 require physicians to carry malpractice insurance as a condition of medical staff membership at Evergreen?

BACKGROUND

Nationally, hospitals are finding that the courts are holding them vicariously liable for all negligence which occurs on hospital premises. Hospitals are increasingly at risk as the "deep pocket" for multimillion dollar settlements in malpractice suits in which a defendant physician's personal malpractice coverage is low or nonexistent. In order to protect the assets of the hospital in this changing legal environment, some boards of trustees are requiring physicians to carry malpractice insurance as a condition of medical staff membership. (Attached as Appendix A is an article from the August 1982 issue of *The Hospital Medical Staff* which outlines the problem in some detail.)

CURRENT STATUS

1. In the Seattle area, only a few community hospitals currently have a malpractice requirement in place, but others report they may implement such a requirement in 1983 (See Appendix B for a list of hospitals and current status). Statewide, the Washington Hospital Liability Insurance Fund (WHLIF) reports that 50% of its 74 member hospitals require malpractice coverage.

2. Both our hospital liability insurance through WHLIF and our excess insurance are community, not experi-

ence, rated. This means that in the short run our premiums will not be reduced if we limit our risk by requiring physicians to carry liability insurance, nor will they be raised if judgments are made against us for a physician's liability.

3. WHLIF does not require hospitals to have mandatory medical staff liability coverage as a condition of participation in WHLIF.

4. The most liability coverage a physician can buy in Washington State is $5 million (see WSMA's December 1982 summary of physician liability plans attached as Appendix C). Evergreen has $1 million through WHLIF and $10 million excess for a total of $11 million in liability coverage for the hospital. There is no way for EGH to avoid being the "deep pocket" on major claims as long as EGH maintains its current level of coverage and physicians are limited to $5 million. It is concluded that requiring malpractice coverage of physicians will not appreciably reduce EGH's risk for multimillion dollar claims.

5. To the best of the hospital's knowledge, only one physician on our current active/provisional staff is "bare". This physician is an orthopedic surgeon. Orthopedic surgery is one of the highest risk categories for malpractice suits. WHLIF indicates that for the most recent three year period for which data is available, (1975-1978), 7.6% of total malpractice closed claims were in orthopedic surgery, and these accounted for 9.1% of the total dollar awards made. On a national basis, the probability that an orthopedic surgeon will settle a claim filed against him is about .05 in any given year, with an average award amount of $30,000.

6. The one "bare" physician has been an active member of this medical community including serving as the first Chairman of the hospital's Quality Assurance Program. There are no questions about his competence

nor to the best of the hospital's knowledge, has a suit ever been filed against him. His decision to not carry liability insurance is based on his religious beliefs, and at least a portion of his patients subscribe to his values.

7. In 1982, this "bare" physician admitted 67 patients for a total of 358 patient days. At an average daily revenue of $300, if this physician moved his patience to another hospital (such as Northwest, which indicates it has no intention of requiring malpractice coverage), it would reduce hospital revenues by over $100,000 annually.

8. In private conversations, the one "bare" physician indicates that he is not sure what he will do if EGH imposes a mandatory malpractice coverage requirement. His choices are to obtain coverage, which he indicates would conflict with his religious beliefs; move his practice to another hospital which is what he did when Overlake imposed its malpractice requirement; or legally challenge the hospital's authority to impose such a requirement.

9. WHLF staff report that there is some case law established on this topic, and that to the best of their knowledge the courts have always upheld the right of the hospital to require that physicians have malpractice insurance.

10. In Evergreen's case, it is unclear what the result would be if our one "bare" physician decided to test the issue in courts. Unlike hospitals in other parts of the country which are self insured or carry experience rated liability coverage, Evergreen cannot argue that implementing such a requirement is necessary to protect the assets of the hospital.

11. A number of practical and philosophical concerns have been raised during the past months of formal and in-

formal discussion about this topic. At the meetings of the surgery section in October and November, 1982, a number of surgeons voiced their support for mandatory malpractice coverage. They said that it would be to their advantage to have all their colleagues insured, as they would then be assured that when they made a referral to, performed a consult for, signed out to, or participated in a procedure with another Evergreen physician they would not be placing themselves at "deep pocket" risk for their colleague's possible liability. Other physicians expressed the opinion that malpractice coverage is a private business decision to be made by the individual practitioner, not something that should be dictated by the hospital. One physician was concerned that it was the responsibility of the hospital to insure that quality care was provided, not that payment could be made in case of liability, and that the two issues should not be confused. The surgical section vote was split 7-6 in favor of requiring malpractice coverage.

12. The Executive Committee discussed the topic at its September meeting and voted to do nothing now but review the issue again in a year.

13. Another concern that has been raised by some physicians is that if more hospitals in the area start requiring malpractice coverage EGH could become a magnet for physicians who can't get coverage. Other physicians counter this argument saying that our Credentials Committee protects the hospital against this possibility by continued thorough review of every applicant for membership. If someone is unable to get malpractice coverage for practice reasons, the practice concerns alone will probably be enough to keep that physician from being accepted on the staff without relying on the malpractice coverage issue to exclude problem physicians.

14. Recognizing that accidents do happen, it has been argued in earlier Joint Conference Committee discussions on this topic that the hospital may have a duty to assure its patients and/or the community at large that they will be compensated if they are injured by a member of our medical staff. However, there is nothing in district law to suggest that this is a legal obligation of the Commissioners nor is it addressed in JCAH standards.

15. Another facet of the problem that has been discussed is the case law that suggests that the hospital is placing itself in a unique legal position when it refers or assigns a patient to a physician the patient has not selected independently, such as in the Emergency Department. Following this line of thought, it has been suggested that the hospital should restrict its Physician Referral Service and Emergency Department call rotation to physicians who have malpractice coverage. However, as noted above, EGH's insurance premiums will not be reduced if we take this action, nor will our "deep pocket" position be eliminated.

16. Two of the hospitals we surveyed on this topic commented that they ran into problems when they tried to establish what they considered "adequate" coverage limits. One ended up backing down to token coverage limits of $100,000/$300,000 and the other is still embroiled in a board level discussion of what limits should be established by specialty.

CONCLUSION

Based on the above, the following conclusions can be drawn:

Financially, our situation is unlike some other areas of the country. In states where hospitals are primarily self insured or participate in experience-rated liability programs, hospitals have been able to save premium dollars and/or settlement payouts by requiring their medical staffs

to share in the liability burden by carrying malpractice insurance. Due to the way our liability coverage is structured, there is no financial reason for Evergreen to require our medical staff to carry malpractice coverage.

Legally, there appears to be no legal obligation or authority for the hospital to assure either its patients or the community at large that the members of its medical staff have malpractice coverage.

Practically, establishing a malpractice requirement could embroil us in a suit with our "bare" physician. This individual is a well respected, longstanding member of the medical staff who probably can marshall considerable support from patients and members of the community who agree with or will defend his right to maintain his religious convictions on this issue.

RECOMMENDATION

After reviewing the unique characteristics of our liability coverage, recommendation is as follows:

1. That we not pursue implementation of a mandatory malpractice coverage requirement at this time.
2. That we recommend WHLIF to make mandatory malpractice coverage requirements a condition of all hospitals' participation in WHLIF, so that the risk profile of the entire pool can be reduced for long term premium control.

[ATTACHMENTS OMITTED]

APPENDIX E

MINUTES

[Excerpts of Minutes From July 15, 1982 to May 24, 1983 from Meetings of the Board of Commissioners of King County Public Hospital District No. 2, Joint Conference Committee and Executive Committee of Evergreen General Hospital]

JULY 15, 1982 ***Joint Conference Committee***

In addition, the committee discussed the lack of any requirement in the medical staff bylaws that physicians carry malpractice insurance as a condition of membership on Evergreen's medical staff. Comm. Ellingson asked Mr. Fallat to research this question and make a recommendation to the committee.

JULY 27, 1982 ***Board of Commissioners***

Board Committees Joint Conference Committee	Comm. Ellingson reviewed the Joint Conference Committee minutes of July 15, 1982. . . . Comm. Ellingson said that Mr. Fallat will be reviewing the medical staff bylaws regarding physicians carrying malpractice insurance.

AUGUST 23, 1982 ***Joint Conference Committee***

Mrs. Zoloth reported that of the local suburban hospitals surveyed recently, only one medical staff (Overlake) currently requires evidence of malpractice coverage as a condition of medical staff membership. However, a majority of the hospitals in the area reported that they plan to require malpractice coverage within the next year.

The committee requested that the question of whether Evergreen General Hospital should require evidence of malpractice coverage for medical staff membership, and if so, at what limits, be referred to the Executive Committee of the medical staff for review.

AUGUST 24, 1982 ***Joint Conference Committee***

Board Committees
Joint Conf. Committee

Comm. Ellingson reported on the August 23 Joint Conference Committee meeting. . . . Professional liability insurance requirements for medical staff was also discussed and was referred to the Executive Committee for their recommendation. (Minutes attached to Board minutes.)

SEPTEMBER 16, 1982 ***Executive Committee***

The Joint Conference Committee requested that the question of whether the hospital should require evidence of malpractice coverage for medical staff membership, and if so, at what limits, be referred to the Executive Committee of the medical staff for review. Considerable discussion ensued, Ms. Zoloth reported that her poll of other suburban community hospitals revealed that only one currently requires malpractice coverage but that other hospitals are studying the issue.

Dr. Lipsky moved that the Executive Committee, after due consideration, at this time not adopt a requirement for malpractice insurance at this time, but that this issue be reconsidered in one year. Dr. Watts seconded the motion. Motion carried unanimously.

Dr. Cufley will announce this decision at the General Staff meeting.

SEPTEMBER 28, 1982 ***Board of Commissioners***

Dr. Cufley reported the Executive Committee voted to not adopt a requirement for malpractice insurance at this time. He said the Committee members felt that malpractice insurance does not relate to patient care and they did not believe it should be mandatory.

The commissioners still expressed concern about professional liability insurance and it was referred back to the Joint Conference Committee to review again.

OCTOBER 7, 1982 ***Joint Conference Committee***

The question of whether the hospital should require evidence of professional liability coverage as a condition of medical staff membership was discussed. The consensus was that there would be no easy answers but that further review and discussion with the medical staff was necessary.

One area of concern identified by the committee was the practice of allowing physicians who do not carry liability insurance to take back-up call for the Emergency Room where the expectation of the public is probably that any physician the hospital calls in to care for them would have such coverage. The topic was referred to the Executive Committee for further review.

JANUARY 7, 1983 ***Joint Conference Committee***

Mr. DeYoung asked for clarification on the timetable for Board discussion of whether or not physicians should be required to carry professional liability insurance before they can practice at Evergreen. It was agreed that Mr. Fallat would have a recommendation for JCC review in February and Board discussion in March.

JANUARY 25, 1983 ***Board of Commissioners***

Comm. Ellingson reviewed the Joint Conference Committee minutes of January 7, 1983 (copy attached to official minutes) and said that the committee discussed whether or not the Board should require physicians to have malpractice insurance. She said the Committee asked Mr. Fallat to make a recommendation at the next Joint Conference Committee meeting.

FEBRUARY 22, 1983 ***Joint Conference Committee***

The single topic on the agenda was discussion of whether the Board of Commissioners should require physicians to carry malpractice insurance as a condition of medical staff membership at Evergreen. The discussion paper that was distributed to the committee members prior to the meeting is attached to the original of these minutes. The recommendation of administration was:

1. That we not pursue implementation of a mandatory malpractice coverage requirement at this time.
2. That we recommend WHLIF to make mandatory malpractice coverage requirements a condition of all hospitals' participation in WHLIF, so that the risk profile of the entire pool can be reduced for long term premium control.

Discussion centered on three areas:

1. Administration's rationale for not recommending mandatory malpractice coverage as presented in the discussion paper.
2. The Commissioners' philosophy regarding this topic and the responsibility and authority to set policy for the district.
3. Implementation steps if should the Board adopt this policy. [sic]

No consensus was reached on whether the hospital should establish this requirement. Commissioners Ellingson and DeYoung stated that they were in favor of making malpractice coverage mandatory; Mr. Fallat indicated administration's recommendation remained to work instead with WHLIF to reduce the "uncovered" physician risk for the entire pool of the WHLIF hospitals. The medical staff representatives abstained, noting that malpractice insurance is a hospital business problem outside the medical staff's responsibility for quality of care.

It was agreed to take the issue to the full Board at its March meeting for discussion and possible action.

FEBRUARY 22, 1983 ***Board of Commissioners***

Comm. Ellingson reported the Joint Conference Committee met this evening to review the issue of whether the Board should require physicians to carry malpractice insurance as a condition of medical staff membership at Evergreen. Management's report indicated there would be no reduction on the hospital's premium to WHLIF if the hospital requires malpractice insurance; however, some of the committee members felt that in the long run there may be an increase in premiums if losses were incurred. She said if the Board requires malpractice insurance it would be a policy decision as the Board does not have the legal obligation to require it. She indicated another alternative which would lessen the risk of "deep pocket" would be to remove uninsured physicians from the Doctor's referral system and Emergency Department back-up call schedules.

Management staff's recommendation to the Joint Conference Committee was not to pursue implementation of a mandatory malpractice coverage requirement at this time and to recommend that the WHLIF make mandatory malpractice coverage requirements a condition of all hospitals' participation in WHLIF.

Comm. Ellingson reported a motion was made to require mandatory malpractice insurance as a condition of medical staff membership with levels of $100,000/$300,000 but there was not a consensus on the motion.

Comm. Goeppele moved to defer discussion and action on the issue of the mandatory malpractice insurance until the next meeting with the provisio that the management staff's discussion paper be distributed to the entire Board. Motion seconded by Comm. Barrett. Motion carried unanimously. A change in the hospital bylaws will be required if man-

datory malpractice insurance is required and a rewording of the bylaws will be drafted for the next meeting.

APRIL 26, 1983 ***Board of Commissioners***

The Commissioners received the proposed amendment to Article VIII of the hospital bylaws in March. The Joint Conference Committee recommended this amendment be approved.

Comm. Goeppele moved to amend Article III of the hospital bylaws to read (Insert new Section 1.B as follows, and renumber current 1.B-1.H as 1.c-1.1) "The commission shall require each physician and AHP requesting privileges to practice at Evergreen General Hospital to show evidence at time of initial appointment and annually thereafter that he carries professional liability insurance in amounts considered adequate by the commission. The commission shall establish minimum coverage limits by specialty for the next calendar year annually at its July meeting. Failure of any medical staff member or AHP to maintain established minimum liability coverages shall result in summary suspension of his privileges as provided in Paragraph F below." Motion seconded by Comm. DeYoung.

Comm. Goeppele moved to amend the motion to defer implementation of the bylaw revision until July 1, 1983 with the provisio the Joint Conference Committee provide the Board with recommendations for professional liability insurance limits prior to July 1, 1983. Motion seconded by Comm. DeYoung. Motion carried unanimously.

Comm. Ellingson asked for the question on the original motion as amended. *The original motion as amended was carried unanimously.*

MAY 20, 1983 ***Joint Conference Committee***

1. *Implementation schedule for requiring physicians to document that they have adequate liability coverage.*

The timing of the planned implementation of mandatory medical staff liability coverage was discussed. It was the consensus of the committee that the intent of the Board of Commissioners, as reflected in its April 26th minutes was to apply this requirement to all current members of the staff effective on July 1, 1983. It was agreed that formal notice to physicians of this requirement should go out immediately following the Board meeting on Tuesday, May 24, to give physicians approximately five weeks to comply and arrange with their carriers to provide a certificate of insurance to the hospital for documentation.

2. Recommendation for Board regarding minimum dollar amounts of coverage.

   The committee reviewed the current levels of insurance carried by members of the medical staff and the requirements established by other area hospitals. Comm. Ellingson moved that the committee recommend to the Board of Commissioners that all physicians and Allied Health Professionals, regardless of specialty, be required to document professional liability coverage in the amounts of $100,000 per occurrence and $300,000 in aggregate for the period between July 1, 1983 and December 31, 1983 and further that these minimum requirements be increased to $1,000,000 per occurrence (with no minimum aggregate established) for calendar year 1984. Comm. DeYoung seconded the motion. Motion carried unanimously.

3. *Enforcement.* Dr. West asked how this provision would be enforced. Marty Zoloth responded that since it is a governing body requirement, not a medical staff requirement, enforcement should follow the procedures outlined in the governing body bylaws. It was agreed that the committees should review these pro-

cedures for familiarity and possible updating to insure due process is provided.

MAY 24, 1983 ***Board of Commissioners***

Comm. DeYoung said the Joint Conference Committee recommends the board approve the following professional liability limits for all physicians and allied health professionals as a requirement for medical staff privileges at Evergreen Hospital: $100,000 per occurrence and $300,000 in aggregate for the period between July 1, 1983 and December 31, 1983 and that the minimum requirements be increased to $1,000,000 in 1984. Comm. DeYoung said that a formal notice would go out from administration immediately following this board meeting to give the physicians approximately five weeks to comply with this requirement.

Comm. DeYoung moved to approve the recommendation of the Joint Conference Committee that all physicians and allied health professionals, regardless of specialty, be required to document professional liability coverage in the amounts of $100,000 per occurrence and $300,000 in aggregate for the period between July 1, 1983 and December 31, 1983 and further that these minimum requirements be increased to $1,000,000, with no minimum aggregate established, on January 1, 1984. Motion seconded by Comm. McClintick. Motion carried unanimously.

APPENDIX F

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DECISION OF BOARD OF COMMISSIONERS OF KING COUNTY PUBLIC HOSPITAL DISTRICT NO. 2

In re

WILLIAM BACKLUND, M.D. }

THIS MATTER having come on regularly for hearing before the Board of Commissioners of King County Public Hospital District No. 2 on the 13th day of October, 1983, and the hearing having been continued from time to time at the mutual agreement of the Hospital and William Backlund; and William Backlund being represented by Nathan James Neiman, Attorney at Law, and Evergreen Hospital being represented by Charles E. Watts, Attorney at Law, and the Board of Commissioners of King County Public Hospital No. 2 having held a full and complete hearing to consider the proposed suspension of Dr. Backlund's privileges from the medical staff at Evergreen General Hospital on December 8, 1983, at the hour of 7:00 o'clock p.m., and the Board having deliberated thereafter and concluding that Dr. Backlund's privileges to practice medicine at Evergreen General Hospital be and the same should be suspended.

NOW, THEREFORE, the Board of Commissioners of King County Public Hospital District No. 2 does hereby enter and make the following Findings, Facts, Conclusions of Law and Decision.

FINDINGS OF FACT

1. William Backlund, M.D., is a member of the medical staff of Evergreen General Hospital.

2. Evergreen General Hospital is owned and operated by King County Public Hospital District No. 2, a Washington municipal corporation.

3. That the Board of Commissioners of King County Public Hospital District No. 2 amended the Bylaws of Public Hospital No. 2 on June 28, 1983 to add paragraph VIII, Section 1(B) which provides as follows:

> The commission shall require each physician and AHP requesting privileges to practice at Evergreen General Hospital to show evidence at time of initial appointment and annually thereafter that he carries professional liability insurance in amounts considered adequate by the Commission. The Commission shall establish minimum coverage limits by specialty for the next calendar year annually at its July meeting. Failure of any medical staff member or AHP to maintain the establishment and liability coverages shall result in suspension of his privileges and as provided in paragraph F below."

4. That William Backlund was advised of the proposed requirement for professional liability insurance coverage on the 27th day of May, 1983.

5. That William Backlund, M.D., has failed to deliver a Certificate of Proof that he maintains professional liability insurance in accordance with the Bylaws of Evergreen General Hospital.

6. That on or about the 5th day of July, 1983 the Hospital Administration advised William Backlund, M.D., in writing, of his failure to comply with the Hospital District Bylaws, and that if he continued to fail to comply therewith, that his privileges to practice medicine at Evergreen Hospital would be suspended. Dr. Backlund was furthermore advised that he was entitled to challenge his suspension.

7. On or about the 8th day of July, 1983 William Backlund gave notice of his challenge of the proposed suspension of his privileges, and requested a hearing before the Joint Conference Committee.

8. That the Joint Conference Committee of Evergreen Hospital conducted a hearing on the 21st day of July, 1983 at the hour of 7:00 o'clock p.m. That at said hearing the Hospital was represented by Marty Zoloth, Assistant Administrator and William Backlund was present and represented by Nathan James Neiman, Attorney at Law. The record of said proceedings was reported by Julie C. Oswald, Court Reporter. The Committee was represented by Philip L. Carter of Livengood, Silvernale, Carter & Tjossem, counsel to King County Public Hospital District No. 2.

9. That following the hearing before the Joint Conference Committee, the Committee entered certain Findings of Fact and Conclusions and a recommendation to the Board of Commissioners of King County Public Hospital District No. 2.

10. That the Joint Conference Committee of Evergreen General Hospital concluded that all physicians are required to carry professional liability insurance in accordance with the Bylaws of King County Public Hospital District No. 2, that William Backlund, M.D. had failed to provided evidence that he carried such professional liability insurance as required by Article VIII, Section 1(B) of the Hospital Bylaws and that Dr. Backlund had failed to conform to the requirements of the Hospital District Bylaws.

11. The Joint Conference Committee of Evergreen General Hospital after making the foregoing Findings of Fact and Conclusions of Law recommended that the Board of Commissioners of King County Public Hospital District No. 2 grant a hearing to William Backlund.

12. That the Board of Commissioners of King County Public Hospital District No. 2 duly considered the recommendation of the Joint Conference Committee and agreed to conduct its own hearing.

13. That the Board of Commissioners of King County Public Hospital District No. 2 convened a hearing regard-

ing Dr. Backlund's privileges and proposed suspension thereof on October 13, 1983, which hearing was continued at the mutual request of William Backlund and the staff of Evergreen General Hospital.

14. That a hearing was conducted before the Board of Commissioners of King County Public Hospital District No. 2 on the 8th day of December, 1983 commencing at the hour of 7:00 o'clock p.m. That all of the commissioners of King County Public Hospital District No. 2 were present and in attendance during the entirety of said hearing.

15. That the Bylaws of King County Public Hospital District No. 2 were adopted on the 4th day of February, 1976, and were thereafter amended on the 26th day of January, 1982, the 26th day of April, 1983, and the 28th day of June, 1983.

16. That Article VIII, Section 1(b) requires that all physicians maintain professional liability insurance and provide proof of said insurance to the hospital.

17. That William Backlund has failed to purchase professional liability insurance notwithstanding the requirement of the Hospital District Bylaws.

18. That William Backlund has not attempted to procure professional liability insurance coverage despite the Bylaws requirement.

19. That William Backlund has shown no financial hardship nor inability to procure the required professional liability insurance in the amount of $100,000.00 per incident, and $300,000, aggregate.

20. That based upon the evidence professional liability insurance coverage is available to physicians such as William Backlund through as many as three separate carriers.

21. That it is recognized that if a physician makes an error or omission which causes harm to a patient, within the Hospital, it is likely that not only the physician, but

that the Hospital will be named in any subsequent claim or lawsuit, as a party defendant.

22. That the "deep pocket" theory of litigation is well and commonly known, and it is likely that if a suit or claim were commenced against a physician and the Hospital due to an alleged error or omission that took place at the Hospital, and if through discovery in such a proceeding, it were determined that the physician were uninsured, it is likely that the claimant would attempt to pursue the Hospital for full financial responsibility.

23. That the Hospital, named as a party defendant in a suit with an uninsured physician, may be compelled to exert greater administrative and staff effort in the preparation for defense of a malpractice claim if the physician involved is uninsured, inasmuch as said physician will not have the assistance of an insurance carrier in the preparation of the defense of his claim.

24. That RCW 4.22.030 relating to contribution amongst joint tortfeasors where the claims are indivisible, may very well place at risk the Hospital for the full amount of any claims by an injured patient even if the majority of the negligence, as would be determined by a trier of facts, were determined to be the negligence of an uninsured physician. Because of the potential of joint and several liability, it is entirely conceivable and even likely that in such a situation the Hospital, or its insurance carrier, the Washington Hospital Liability Insurance Fund, could bear a greater share of the financial burden if the physician were uninsured.

25. That testimony indicates that settlement negotiations with a plaintiff/claimant where the physician is uninsured, are more difficult and potentially more costly to the Hospital than where the physician carries professional liability insurance coverage.

26. That Evergreen Hospital is a participant in the Washington Hospital Liability Insurance Fund and main-

tains professional liability insurance in an amount of $1,000,000.00, with $10,000.000.00 of excess coverage.

27. That where claims are made against hospitals, the costs of defense and the cost of settlement or payment of said claims is borne by the fund and the participants in the fund, including Evergreen Hospital. While it may be difficult to quantify, there is no question that the more that the fund has to pay in defense of or payment or settlement of claims, the more costly the coverage is to the participants in the fund, including Evergreen Hospital. There is adequate evidence to show that where a physician is uninsured, and the Hospital is named as a party defendant in a claim which arises out of the negligence of a physician in a hospital setting, where the the physician fails to maintain professional liability insurance, additional costs and expensed are incurred or may be incurred by the fund, which costs and expenses are then borne by the participants in the fund, including Evergreen Hospital.

28. That it is prudent that the Board of Commissioners exercise reasonable efforts to protect the assets of the Hospital District, and that the Hospital District should maintain a reasonable level of professional liability insurance coverage itself, and that requiring such coverage of physicians practicing at the Hospital is a reasonable and logical extension of the fiduciary duty of the Hospital District.

29. That where a physician is not covered by professional liability insurance, it may cause the physician, as well as the Hospital to practice defensive medicine, in order to protect the assets of the physician and the Hospital. Defensive medicine tends to lead to ordering tests and procedures which might not ordinarily, within the purview of the practice of good medicine, be done except to protect against malpractice claims. This practice should be avoided because of the extra costs to the patient and the community.

30. That Dr. Backlund professes to have a conviction, based upon his religion, that he should not purchase professional liability insurance coverage.

31. That the tenets or dogma of Dr. Backlund's faith do not preclude the purchase of professional liability insurance. That Dr. Backlund's minister, Patrick Joseph Hammond, testified that he attempted to convince Dr. Backlund to procure the professional liability insurance required by the District Bylaws.

32. That Dr. Backlund's conviction with respect to professional liability insurance appears to be a unique position professed to be held solely by himself.

33. That notwithstanding Dr. Backlund's position regarding professional liability insurance coverage, he maintains automobile insurance because it is required by the lease company from which he leases his automobile, and he also maintains homeowner's insurance because his mortgage lender requires it. His position with respect to maintaining professional liability insurance and automobile and homeowner's insurance appears to be inconsistent because Dr. Backlund indicated that the homeowners and automobile insurance are maintained for business reasons, and yet he refuses to procure professional liability insurance for similar business reasons.

34. That required professional liability insurance for physicians at Evergreen Hospital does not unreasonably interfere with Dr. Backlund's religious conviction, or impede his ability to earn a living. Dr. Backlund is free to practice medicine elsewhere, in other hospitals wherein professional liability insurance is not required or in the alternative, he is free to purchase professional liability insurance and have his suspended privileges at Evergreen reinstated.

35. The affidavit submitted by Al Gray, former administrator of Evergreen Hospital, did not indicate that

professional liability insurance would not be required in the future but only indicated that it was not a requirement as of the date when Dr. Backlund asked Mr. Gray about the Hospital's requirements regarding professional liability insurance.

36. All physicians practicing within Evergreen Hospital are bound by the Bylaws of King County Public Hospital District No. 2 as well as the Medical Staff Bylaws.

37. That Dr. Backlund appears to be sincere in his beliefs and appears to have held them for sometime.

38. That given Dr. Backlund's specialty, as an orthopedic surgeon, many types of cases which he treats are on an emergency basis where he could not adequately inform the patient of his religious beliefs or convictions in such a fashion that the said patient would have freedom of choice.

39. That it is impossible to procure a release of liability for malpractice, the same being against public policy.

40. That while it might be difficult to quantify the detriment to the Hospital by a physician not maintaining professional liability insurance coverage, as required by the Bylaws, such detriment or potential thereof clearly exists although shared by all of the hospitals within the Washington Liability Insurance Fund. That just because it is difficult to quantify the detriment does not mean that the detriment does not exist.

41. That the study paper dated February 18, 1983, was a study paper prepared by the administration of Evergreen General Hospital, and not a study paper endorsed by the Joint Conference Committee of Evergreen General Hospital nor the Board of Commissioners of Evergreen General Hospital.

42. That the Hospital District possesses the authority to require mandatory professional liability insurance coverage of physicians practicing within the Hospital.

43. That if a physician were allowed to practice in contravention of the Hospital District Bylaws requiring the maintenance of professional liability insurance, the patients and/or taxpayers of the District may have to bear additional costs and expenses which would otherwise be borne by the physician's professional liability insurance carrier.

FROM THE FOREGOING FINDINGS OF FACT, THE BOARD MAKES THE FOLLOWING CONCLUSIONS:

1. That Bylaw 8, Section 1(B) requires that all physicians on the active medical staff at Evergreen Hospital maintain minimum levels of professional liability insurance, and said requirement is a reasonable one.

2. That William Backlund, a member of the active medical staff of Evergreen Hospital, has knowingly and willfully failed to procure such professional liability insurance coverage in direct contravention of the Bylaw requirement.

3. That pursuant to the Bylaws of King County Public Hospital District No. 2, the Board of Commissioners has the right to suspend the privileges of any physician who fails to comply with the rules and regulations of the Hospital, or the Bylaws.

4. That William Backlund's failure to comply with the Bylaw requirements relating to professional liability insurance constitutes grounds for his suspension from the active medical staff and such failure or refusal to procure professional liability insurance coverage, and to show proof thereof, constitutes conduct which is detrimental or could be detrimental to the administration of the Hospital or the medical care of the patients of the Hospital as provided in Article 8, Section 1(F) of the Hospital Bylaws.

WHEREFORE, it is the decision of the Board of Commissioners of King County Public Hospital District No. 2 that effective December 12, 1983, the privileges of Dr. William Backlund to practice medicine at Evergreen General Hospital be and the same are hereby suspended and

the Board reaffirms its commitment to uphold the uniform application of the Bylaws to all physicians.

ADOPTED unanimously this 12th day of December, 1983.

/s/ C. POLLY ELLINGSON
CHAIRPERSON

/s/ AL DEYOUNG
SECRETARY PRO TEM

/s/ HERMANN GOEPPELE
COMMISSIONER

/s/ RUSSELL L. MCCLINTOCK
COMMISSIONER

_____
COMMISSIONER

APPENDIX G

IN THE SUPERIOR COURT
OF THE STATE OF WASHINGTON
IN AND FOR THE COUNTY OF KING

83-2-17152-1

WILLIAM BACKLUND, M.D.,
Plaintiff,

vs.

THE BOARD OF COMMISSIONERS, EVERGREEN GENERAL HOSPITAL, KING COUNTY HOSPITAL DISTRICT NO. 2,
Defendant.

COURT'S ORAL DECISION
HEARD BEFORE: THE HONORABLE ROBERT M. ELSTON

APRIL 20, 1984

KING COUNTY COURTHOUSE

SEATTLE, WASHINGTON

APPEARANCES. NATHAN JAMES NEIMAN, representing the plaintiff;

PHILLIP L. CARTER, representing the defendant.

MORNING SESSION

April 20, 1984
9:30 o'clock a.m.

THE COURT: Good morning.

MR. NEIMAN: Good morning. MR. CARTER: Good morning, your Honor.

THE COURT: This case as the parties particularly through counsel have very adequately pointed out, involves a challenge of the bylaws of the Evergreen General Hospital requiring physicians to have professional liability insurance as a condition of being allowed to practice within the hospital. That bylaw is contained in Article 8, Section 1 of the hospital's bylaws.

The case obviously is important to the parties involved and it involves substantial interests, not only to those directly involved and the reviewing Court, but also to the community generally because of the significance of the considerations involved.

I have considered the entire record, including the transcript of testimony at both the Joint Conference Committee hearing and the Board of Commissioners' hearing, the exhibits that were introduced at those hearings and provided here, and the briefs or memoranda of authority that were submitted both to the administrative tribunals and to this Court.

I want to assure everyone that I will hope not to labor this opinion with overly detailed recitations of the evidence presented or the authorities cited. I have considered everything. Whether I mention them specifically or not does not mean that they were not considered and it does also not mean that they were regarded as having little or no importance.

The importance of those aspects of the evidence and the authorities cited where I felt appropriate, will work

their way into the oral opinion. They do adhere in the determinations made, and I want to give everyone assurance that they have been considered. I wish I could give like assurance that they have been properly applied and properly construed, but that involves a rather subjective working of the mind and I simply have done my best with that.

The case has some additional interest or significance because, as Mr. Neiman pointed out in his argument, it is a matter of first impression. There are other cases that have similar issues, but this appears to be the first instance in Washington where the precise issue involved in this case has been raised.

I do wish to express my appreciation for the excellence of the presentations of both parties, both as to the comprehensive and well written briefs or memoranda of authority that were submitted and the exceptionally able arguments that occupied all of yesterday by both parties. The quality of representation of both parties is exemplary in this case. I certainly appreciate it and I hope that the parties represented recognize the quality representation that has been provided in each case.

Those of us who work in the law are well aware of the restrictions upon judicial review of administrative decisions. Those restrictions require the application of a discipline to observe them, regardless of sometimes very compelling feelings that might cause one to wish he or she could operate outside of that discipline.

One of the most difficult aspects of judicial review of administrative hearings to apply is that the reviewing Court may not substitute its judgment for the judgment of the administrative tribunal, even though the reviewing Court might disagree with the determinations that were made, and I believe I can successfully resist the temptation to substitute my judgment for the judgment of the Board of Commissioners.

The scope of review that the Superior Court has in considering an administrative review is that the Court may affirm the decision of the tribunal, that is, the Board in this case, or the Court may remand the case for further proceedings or the Court may reverse the decision if the substantial rights of the petitioner have been prejudiced because of the administrative findings, conclusions and decision, if those findings are either in violation of constitutional provisions or in excess of the statutory authority or jurisdiction of the agency or made upon unlawful procedure or affected by other error of law or if the result at the administrative level is clearly erroneous in view of the entire record or if the record demonstrates that the action taken was arbitrary or capricious.

Arbitrary or capricious is a concept that means that there has been a willful and unreasoning action without consideration of and in disregard of the facts and circumstances, and, again, this clearly goes beyond simply a disagreement with the result.

This case has presented a number of issues contained or identified at least in part by petitioner's brief under a subheading of doctor's position with respect to enumerated claims of error, but I believe that the basic issues in this case are two. First, is the bylaw valid? Secondly, does the bylaw apply to Doctor Backlund?

During argument yesterday there was a suggestion that one resolution of this case would constitute something of a compromise or represent a compromise result. Compromise is proper in some instances but it is not proper in the determination of a judicial decision. Compromise is appropriate and undoubtedly helpful in legislation which has repeatedly been defined as the art of compromise, and compromise of litigation short of courtroom determination.

But a Court decision must be based upon the facts and the law and utilizing the facts and the law to arrive at a decision that is correct under the facts and the law re-

gardless of the trier of the fact's personal opinion or belief or without leading the trier of the fact into trying to accomplish through an oral decision a compromise or a settlement based upon considerations that the parties may consider in settlement negotiations and results but which a Court is not entitled to consider.

So, in resolving the two issues that I have indicated, I must do that on the basis of the facts and the law and not upon my own personal notion as to what might represent a rough justice type of result to this case by trying to consider the equities as they relate to both parties and then work out some kind of a disposition that tries to accommodate the positions of both parties, either without regard to or in defiance of the evidence that has been presented or the law that controls the courtroom determination of the issues.

The petitioner has challenged the validity of the bylaw on a number of grounds. This is now a consideration of the first basic issue, whether the bylaw is valid. I do not intend to catalog nor exhaust the contentions made nor the reasons for the determinations as to those contentions. If they are not mentioned, it simply indicates that I have not considered them significant enough to make a separate finding or determination.

The petitioner claims that he was denied procedural and substantive due process and contends that that lack of procedural or substantive due process involves a number of failings on the part of the Board of Commissioners. First, that the petitioner was not afforded adequate or timely notice, specifically, the petitioner's contention is that the notice to the petitioner failed to include a provision reciting that the petitioner's conduct is detrimental or could be detrimental to the administration of the hospital or the medical care of the patients in the hospital.

There is a serious question as to whether to constitute adequate notice that provision would have to be included

in the notice, but I do not believe I have to decide that issue because the petitioner clearly obtained notice and was on notice of the contention that the hospital regarded his failure to obtain professional liability insurance as something that would be detrimental to the administration of the hospital for the medical care of the patients in the hospital.

This was known clearly at least by the time of the Joint Conference Committee hearing, and the hearing that is the subject of this appeal is the Board of Commissioners' hearing at which time there was full knowledge of the position of the hospital. The case of Williams versus School District of Seattle is helpful in analyzing the validity of this claim of defective due process. My finding is that there was adequate and timely notice and that there was no failure to provide due process on that basis.

Another contention of the doctor is that the procedure lacked the appearance of fairness. It is clear that there has been no showing nor any attempt to show apparently that any member of the tribunal did have any bias individually. The contention is that because the Board was constituted by persons including those who enacted the bylaw and who also sat on the Joint Conference Committee hearing, that this would cause a reasonably prudent and disinterested observer to conclude that all parties involved in the hearing did not obtain a fair, impartial and neutral hearing.

There is no showing that the Board as constituted lacked the appearance of fairness, if that doctrine applies, and there is a question. There seems to be at least as much of a question in the Supreme Court as there is among persons here as to whether the doctrine of appearance of fairness applies because of the somewhat inconsistent positions in appellate decisions with respect to whether it involves only a statutorily required hearing situation or whether it would apply in any public hearing.

For the purpose of this case, I am adopting what seems to be a preferred interpretation of the decisions, that if there is a public hearing, it should have the appearance of fairness and it should not rely upon some artificial standard as to whether it is a statutorily required hearing.

To the persons involved in a hearing it is a matter of their perception of fairness of that hearing and not whether it comes within some favored category of hearing. But there is nothing in the record here to show that there was any violation of the appearance of fairness. The fact that a person has some knowledge of the facts that might be involved in the evidence or the hearing is not a sufficient showing. The fact that the Board enacted the bylaw does not indicate that members of the Board would approach a hearing as to whether the bylaw applied to Doctor Backlund with any predisposition. So my finding is that the procedure did not violate the appearance of fairness doctrine.

Even if it did, then there must be considered the concept of the doctrine of necessity. In this case the Board was the only Board constituted to conduct the hearing. There was no provision indicated by counsel as to what substitute tribunal might hear the matter if there was a violation of the appearance of fairness, and there was no mechanism provided to suggest how a substitute tribunal with authority could be assembled and constituted to hear the proceeding. But my basic finding is that there was no violation of the appearance of fairness doctrine. If that finding is erroneous, then I think there is a clear showing that the doctrine of necessity would apply.

Another contention of the petitioner is that he was denied due process because the insurance requirement was enacted in excess of the Board of Commissioners' jurisdiction. My conclusion is that there is no state constitutional or statutory provision that would exclude a hospital Board from adopting reasonable measures to conduct the

business of the hospital. I do not believe that the matters upon which the Board acted here were preempted by the state constitution nor any state statute nor any decision of an Appellate Court.

The one statute that has particular significance is RCW 70.44.003 which authorizes the establishment of public hospital districts to own and operate hospitals and other health care facilities or services for the residents of the district and other persons. That statute obviously carries with it the authority to establish a public hospital, and establishment of a public hospital then imposes the natural subsequent duty to operate the hospital. A hospital cannot be operated in a vacuum and must consider its own staff, including the medical staff and the patients and what is required. Obviously, the hospital would not be free to adopt measures that would conflict with the standards established by state authorities.

Another claim of violation of due process that Doctor Backlund makes is the finding that mandatory professional liability insurance is reasonably related to the effective functioning of the hospital as not being supported by the evidence. The petitioner appears to place great reliance upon the significance of the Joint Conference Committee discussion paper, but that paper was not something binding on the Board of Commissioners.

The Board of Commissioners is the policy making unit of the hospital. The discussion paper was prepared by the hospital staff, and I believe it is basic that the policy making group of any organization is not bound by recommendations of the staff of that organization. If that were the case, then, of course, there would be no purpose in having a policy making Board. There would be no purpose in having a Board of Commissioners of the hospital because if they were bound to accept any recommendation made, they would be nothing more than a redundant rubber stamp type group, which obviously is not contemplated

in the constitution of hospital Boards of Commissioners whose members are elected by the public within the district.

In this area particularly I must observe the discipline that I am not at liberty to disagree with the factual determinations of the Board of Commissioners. I say that because some of the findings of the Board of Commissioners are more in the nature of opinions or speculations than Findings of Fact based upon evidence. But I must as the law requires, defer to the expertise of the Board of Commissioners.

I do recognize that the medical field, and particularly the administration of a hospital, involves expertise and experience as well as the precise evidence presented before it, and some of the findings that talk in terms of might or could, do have that favored interpretation. I'm not intending to say that I necessarily disagree with those findings, but simply that they are accepted and that I am not at liberty to really weigh them or consider whether I agree or disagree.

The petitioner contends that he did not receive a fair and impartial hearing. That is a rather general type of consideration. The Ritter case provides that the administrative body must follow its own rules and regulations when it conducts a proceeding which can deprive a person of a benefit or entitlement.

The petitioner complains about the notice again as failing to include the provision I have mentioned, and that being violative of its own rules and regulations. My conclusion is that there was nothing that the Board did that violated its own rules and regulations with respect to the hearing. The Board instead provided a commendably fair setting for a hearing. The environment of the hearing was conducive to a fair hearing.

The observance of the necessary elements of a fair hearing were laudable. The Board provided notice. All Board

members were present at the hearing. The hearing was a lengthy hearing. All Board members remained throughout the hearing so that those who decided were those who heard. The petitioner was given a right and the opportunity which was exercised to cross-examine witnesses and challenge evidence presented. He was given the right to be heard, and the Board provided opportunity for opening statements, the presentation of written memoranda and arguments at the conclusion of the evidence. So it is difficult to conceive of a proceeding which was more fair and impartial.

It is clear from the evidence and the Board's findings that the bylaw was enacted for the purpose of attempting to provide protection to the hospital for potential liabilities that it could incur, perhaps not so much as to the incidence of the event but the extent, and also for the purpose of protecting the patients of the hospital against the potential that they might unwittingly be exposed to medical practices that were not the subject of professional liability insurance to their potential benefit at some time if a mistake was made and there was no resource for responding in damages to the mistake.

So, again, referring to the Ritter case, this Court's inquiry is limited to determine whether the criteria upon which the decision was based was applied fairly and is reasonably related to the effective functioning of the hospital. It is clear that the bylaw was directed at matters of proper concern for the Board of Commissioners of a hospital. The bylaw is not shown to have been enacted for the purpose of inhibiting anyone's religious beliefs or conduct.

The fact that there appears now to be a conflict between that bylaw and a staff physician's religious beliefs is something that is a result of the bylaw but not an objective of the bylaw. Therefore, as to the first issue, is the bylaw

valid, I must uphold the determination of the Board of the hospital and find that it is valid and must be affirmed.

The second issue, does the bylaw apply to Doctor Backlund, involves a somewhat different approach to reviewing the Board's determination. Because there is a claim of violation of a constitutional right, there is a different standard of review, a different test to be applied, and the Court may closely scrutinize the record to resolve the constitutional issues.

The Board did not make much in the way of precise findings or conclusions as to this issue, and I do confess to some confusion in the Board's position as to whether it did, in fact, accept that Doctor Backlund has a religious belief that caused him to refuse to comply with the bylaw or whether he merely professes to have a religious belief that he used or perhaps exploited to avoid compliance with the bylaw.

My finding after reviewing the record very carefully is that the evidence clearly establishes that Doctor Backlund's refusal to comply with the requirement for professional liability insurance was because of his sincerely held religious beliefs. I really do not feel that any other reasonable conclusion is possible under the evidence.

Beginning with the pamphlet that the petitioner has provided to his patients over a period of years long predating the adoption of the bylaw and throughout the years of practice as factually shown in the evidence by the affidavits of various persons who knew him intimately, including associated physicians, patients and others, it is clear that this is not a belief that has been lately developed.

It began early if not at the beginning of Doctor Backlund's practice. It has been followed uniformly since that time. It has not been an uncommunicated belief but has been communicated to patients, prospective patients, as-

sociated physicians, hospital Boards, director, administrator, and all those who might be affected by it.

It is also clear from the evidence that these are personal beliefs of the petitioner. There is no formal precept or dogma of any organized religion apparently to which reference can be made to find any prohibition of having a particular form of insurance, and I can understand that that matter was disturbing to the Board in its consideration of this case and I can understand that the Board might very well have been concerned about the potential for others to attempt to avoid complying with the requirement for professional liability insurance by contending that it conflicts with their religious beliefs.

In this case, again, it is clear that these beliefs long predated the enactment of the bylaw, so that they could not be said to be any kind of response to the bylaws. Secondly, they have been followed uniformly over a period of years in a very public and forthright way by the petitioner.

It is not likely that some other physician if so inclined would be able to advance the same argument with the same compelling force as to why the bylaw should not apply to him or her because it would be necessary for the showing to be that these beliefs had an early origin, that they were openly followed to the notice of anyone even potentially involved over a period of time predating the enactment of the bylaw.

Had the bylaw been enacted, then the pamphlet distributed, prepared and distributed and manifestations made of religious belief forbidding the obtaining of professional liability insurance, then the petitioner's claimed religious beliefs might properly be suspect, but that is not the case here, and the showing is clear. So, there was a question then that the Board should have determined directly, and that is whether those religious beliefs would be the proper

basis for an exception to the requirement of the bylaws with respect to the petitioner.

That issue was suggested in the record. It was not something that was ignored, and there was some consideration of whether an exception might be granted, but that consideration seemed to be based upon financial ability rather than religious beliefs.

It is not entirely impossible, of course, that allowing an exception because of financial ability would place the hospital in greater jeopardy than permitting an exception based upon protecting a religious belief, but that is simply a matter somewhat of opinion and not necessary for determination here.

The Board seems to have questioned two aspects of the petitioner's religious beliefs: First, that there was some imprecision in articulating those beliefs, particularly in the pamphlet in not saying directly that because of my religious beliefs I have decided not to be covered by malpractice insurance.

As has been pointed out in argument, this pamphlet was written relatively long ago as a means of conveying to others the philosophy of the petitioner's practice and the reasons for it, and it is clear, given the opening paragraphs of that paper and the direct statements as well as the conclusion, that the reason for not obtaining professional liability insurance was because of religious conviction, and requiring that to be said in some sort of magical phrase that includes that term is expecting too much of a person who simply is attempting to communicate a very basic aspect of his practice to those who might be involved.

Reading the pamphlet as a whole, I believe there is no escaping the fact that it conveys the idea that this is a matter of religious belief and compliance by the petitioner.

The Board also seemed to have questions as to whether the petitioner's adherence to his beliefs was marred by

inconsistency in the fact that he had insurance on his home as a home mortgage policy and his leased automobile as a requirement apparently of the lessor. Those may at least superficially seem to involve contradictions of faith when compared to the adherence to belief in declining to have professional liability insurance, but there are different considerations.

Obviously, the matter of professional liability insurance through the evidence is a matter of the petitioner's concept of doctor/patient relationships. It is a concept of one's own professional approach to a practice, and it was not limited simply to refusal to obtain professional liability insurance but also involved the collection of accounts and the petitioner's approach to that aspect of his practice which would seem to favorably involve doctor/patient relationships. Those two aspects of his rather unusual if not unique approach to practice are consistent.

One need not or would not necessarily perceive the same sensitivity with respect to relationships between a mortgagor and a mortgagee or a lessor and a lessee of an automobile. Obviously, there is a much lesser human element and communication element involved in the more commercial aspect of home ownership and automobile leasing than there is in the very close personal relationships and professional relationships in an ongoing confidence needing way of conducting a medical practice. So that even if it were permitted to dissect the beliefs into questions of consistency, there are reasons for the apparent inconsistency that are consistent with the petitioner's contention that his religious convictions prevent his obtaining professional liability insurance.

As to this issue, whether the bylaw provision applies to the petitioner, the ordinary or general rule that an enactment such as the bylaw in this case is entitled to every presumption in favor of its constitutionality, is subject to the exception that there is no presumption of constitu-

tionality of any regulation involving civil liberties as indicated by the Holcomb case which also provides that freedom of religion may only be restricted to prevent grave and immediate danger.

So, with that consideration, the test to be applied is the test contended for by the petitioner, that three things must be shown to justify restricting religious conduct. First, the regulation must further a compelling state interest, in this cased a compelling hospital interest; secondly, that the importance of that interest must be demonstrated with factual evidence; and, third, that all possible alternative regulations must be investigated and the one that interferes the least with religious conduct must be chosen.

As to the first of those elements, the furthering of a compelling state interest, there is a Board interest; there is a showing that there is a legitimate Board interest in the regulation and in applying it to all persons who practice at the hospital.

With respect to the second element or requirement, the importance of the interest must be demonstrated with factual evidence, the record here shows that the importance of that interest has not been sufficiently demonstrated with factual evidence. There are some concepts that are considered. They are considered more in and of themselves than as an incident of the evidence presented.

For example, the deep pocket theory that a hospital would be required to respond more fully in damages to a malpractice claimant because the physician did not have insurance, while it has some apparent validity, it would not be obviated by reason of the physician having insurance. It is a factor now under the present arrangement where physicians are limited to the amount of malpractice or professional liability insurance that they can carry and the hospital is allowed to have substantially increased coverage, so that there is at least on a relative basis, a potential application of the deep pocket theory to adversely

affect the hospital if the physician involved in a claim is one who has an inadequate coverage.

There has been a contention that the team approach of practice would be affected adversely if the petitioner were not carrying professional liability insurance. The record does not indicate any instance of anyone refusing to practice with the petitioner either in actuality or in theory. My reading of the record is that not only had no one refused to practice with the petitioner, but no one has been heard to threaten that they would refuse to practice with the doctor; so that that is, while recognizable in concept, something that has not been shown through the evidence.

There is also the theory that if the bylaw does not apply to the petitioner, that this would lead to at least a potential for the practicing of what is called defensive medicine, either by the petitioner, the hospital or others who might be involved in the treatment of a patient. There was a considerable difficulty indicated through the record about being unable to quantify this problem, and that is understandable.

In addition to that, a person's concern for the potential of a malpractice action might very well cause an insured physician as well as an uninsured physician or hospital to practice defensive medicine and to prepare as early as possible in the treatment of a patient for a potential malpractice claim at some time. And the factual showing did involve testimony by the hospital administrator, Mr. Fallat and the assistant administrator, Miss Zolath, that the position advanced in the discussion paper was something they agreed with, that is, not to impose the requirement at this time, to work through the Washington Hospital Liability Insurance Fund, to have it imposed on all hospitals participating in that association. And so there is a failure by the testimony to show that there was a compelling Board

interest to have this bylaw. That does not detract from the finding that it is in the hospital's interest to have it.

The third requirement, that all possible alternative regulations must be investigated and a choice made of the one that interferes least with religious conduct, has not been demonstrated. There has been very little in the record with respect to investigation of possible alternative regulations. There may be something other than excluding a physician from the medical staff of a hospital that would be compatible both with the hospital's requirements and the petitioner's or the doctor's religious beliefs.

The hospital has an understandable concern for the effect of the petitioner becoming involved in the treatment of the patient who is incompetent to make determinations or decisions under the circumstances of the requirement for treatment, someone who is unconscious, someone whose judgment may be affected by medications, someone whose understanding may be limited.

There are a number of reasons why a person might not be able to make an intelligent decision as to whether to be in the care of a physician who refuses to have professional liability insurance, and in those cases, the disclosure that the petitioner has made through his pamphlet and his discussions with patients, his discussions with associated professionals, simply have no opportunity to be appreciated by the patient.

That is a very legitimate concern and one which the doctor's approach to his practice does not adequately cover. But it would seem that there are alternative measures that the hospital could consider, and I am not by indicating alternative measures, making any determination as to the legitimacy of these possible alternatives, because I have not had a sufficient showing as to all of the impacts or inferences that might be involved, but it would seem that the hospital should at least consider whether the alternative of removing the petitioner from its own referral

list so that it is not responsible for referring patients to the doctor who does not have professional medical insurance in violation of the Board's concern, and the alternative of not having the petitioner's name on the duty roster for the emergency room duty so that the potential for an incompetent, mentally incompetent person, one who cannot make a decision as to whether that person chooses to be attended by an uninsured physician or not, is eliminated. Those are matters that may very well accommodate the interests of both parties in this dispute and something that should be considered. Whether they can be utilized is a matter upon which I make no judgment.

The Board has contended that it is concerned with the specter of a catastrophic judgment, and anyone who even superficially reads or listens to the news media must understand that that is more than an idle concern. There are large judgments. There are judgments that may exceed insurance coverage. There are judgments that may exceed the combination of insurance proceeds and private resources of medical practitioners or hospitals, and that is one of the basic reasons why the first issue has been resolved in favor of the hospital.

The Board has also contended that the petitioner should not be afforded protection for his religious views because he has the freedom of practicing elsewhere. The Thomas case quite adequately answers that contention I believe, and it was more directly argued that a person should not be required to adhere to his religious convictions by moving to a more tolerant area or environment.

That is obviously not said in any disparaging way but does clearly illustrate that the person is not required as a price of adhering to religious convictions to accept any kind of second rate or subordinate status. As was argued, if a person wishes to avail himself or herself of public accommodations, in a restaurant, in a hotel or otherwise, it is of little solace if the accommodation of choice is denied

and a substitute provided or suggested. Every person should have the right to eat where they want as long as it is a public accommodation or to have lodging accommodations where they want as long as it is a public accommodation, and a practicing physician should not be required to remove his practice from one hospital to another simply because another hospital does not have a regulation that conflicts with a religious belief.

That seems so basic that it need not be supported by much argument except to say that indulging the same speculation that sometimes was reflected in the record, there may come a time when all hospitals would have this bylaw. Then a person would be denied the opportunity to practice.

There may be legitimate reasons why a physician would choose to practice in a particular hospital, geographical location, physical resources, reputation, staffing, whatever, and a person should not be required unless there is a showing of compelling state interest, to compromise by backing away from a religious belief and moving to another location.

So I do not believe the argument that the petitioner is free to practice elsewhere disposes of the issue with respect to religious freedom. Religious freedom is a protected freedom. It is entitled to full protection, and that is whether it is a clearly recognized universally accepted precept or a sincerely held personal type of concept as long as it is sincere, is truly based upon religious beliefs and is exercised in good faith as the record here has indicated.

For that reason, the Board did fail to exercise its judgment in determining whether there could be an exception made in the case of the petitioner as to complying with the questioned bylaw, and the matter must be reversed and remanded to the Board for that reason.

I believe that covers the issue, but I'm never quite sure so if counsel have questions or need clarification, this would be an appropriate time to indicate.

MR. CARTER: Your Honor, with respect to the final conclusion which is to reverse and remand to the Board for consideration of whether or not an exception is appropriate, I assume that the Court contemplates a hearing would be held wherein evidence would be presented to consider that aspect of the case; is that—

THE COURT: I have stopped short of making that determination. I could remand with specific instructions to require a hearing or whatever, but I have simply chosen to reverse the decision, remand it to the hospital, indicating that there should be consideration of alternative regulations, and it will be a matter then for future determination as to how the matter proceeds.

MR. CARTER: Thank you.

THE COURT: All right. Anything else?

MR. NEIMAN: No questions, your Honor.

THE COURT: Again, thank you for your presentations, including your help on the briefs, Mr. Smith. I have indicated the excellence of the presentations. I have not overstated it. Thank you.

We'll be at recess.

(Court recessed)

IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON FOR KING COUNTY

No. 83-2-17152-1

WILLIAM BACKLUND, M.D., a physician,
Plaintiff,

vs.

THE BOARD OF COMMISSIONERS, EVERGREEN GENERAL HOSPITAL, KING COUNTY HOSPITAL DISTRICT NO. 2,
Defendant.

ORDER CLARIFYING JUDGMENT AND ORDER DATED MAY 8, 1984

THIS MATTER having come on for hearing on January 2, 1985 before the Honorable Robert M. Elston, on motion of the defendant to clarify the judgment and order of this court dated May 8, 1984, and Philip L. Carter of Livengood, Silvernale, Carter & Tjossem being present and representing the defendant, and Nathan James Neiman, attorney at law, being present and representing the plaintiff, William Backlund, and the court having considered the memorandums of law, the declarations and affidavits on file, its prior oral ruling, and other documents on file, and the oral arguments of counsel, and being fully advised, this court makes the following judgment and order:

1. The oral decision of this court rendered on April 20, 1984, and a letter sent to counsel by this court also dated April 20, 1984, and the judgment and order of this court dated May 8, 1984, were not entirely clear and unambiguous in the reinstatement of Dr. William Backlund's "professional staff privileges" at Evergreen General Hospital.

2. That it was the intent of this court to require Evergreen General Hospital to reinstate Dr. William Backlund's staff privileges to admit and treat his own patients at Evergreen General Hospital.

3. That it was not the intent of this court in issuing its judgment and order on May 8, 1984, or its oral decision on April 20, 1984 or the supplemental letter of April 20, 1984 to require the hospital to place Dr. William Backlund on its emergency room call list.

4. The term "professional staff privileges" as defined in the judgment and order dated May 8, 1984, is limited to requiring Evergreen General Hospital to reinstatement of William Backlund's medical staff privileges to admit and treat his own patients at Evergreen General Hospital and is specifically not intended to include a requirement that Evergreen General Hospital place William Backlund on its emergency room call list. [sic]

DATED this 1st day of March, 1985.

/s/ ROBERT M. ELSTON, JUDGE
JUDGE

Presented by:

LIVENGOOD, SILVERNALE,
CARTER & TJOSSEM

/s/ PHILIP L. CARTER
PHILIP L. CARTER
Attorneys for Defendant

Approved As To Form and
Presentation:

/s/ NATHAN JAMES NEIMAN
NATHAN JAMES NEIMAN
Attorney for Plaintiff

APPENDIX H

In The Supreme Court of Washington

[No. 50634-5. En Banc. September 11, 1986.]

WILLIAM BACKLUND,

Respondent,

v.

THE BOARD OF COMMISSIONERS OF KING COUNTY HOSPITAL DISTRICT NO. 2,

Appellant,

[106 Wn. 2d 632, 724 P.2d 981 (1986)]

CALLOW, J.—The Board of Commissioners of King County Hospital District 2 (Board) terminated Dr. William Backlund's hospital privileges at Evergreen Hospital (Evergreen) because of his refusal to purchase professional liability insurance. The Superior Court held that the Board acted unconstitutionally, infringed on Dr. Backlund's right of free exercise of religion as guaranteed by the First Amendment, and ordered the Board to reinstate his privileges at Evergreen.

The issue presented is whether the Doctor's right to religious freedom is infringed unless he is granted an exemption to a hospital bylaw[1] requiring him to carry professional liability insurance. We hold that it is not. We reverse the trial court and reinstate the decision of the Board.

Dr. Backlund is an orthopedic physician practicing in Redmond. In 1974, he applied for staff privileges at Ev-

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[1] The medical staff at Evergreen is subject to the Bylaws of Public Hospital District 2 of King County (bylaws), which are enacted by the Board.

ergreen. Dr. Backlund told the then Hospital Administrator that because of his religious beliefs he would not acquire professional liability insurance. The Administrator informed Dr. Backlund that Evergreen did not require staff physicians to carry such insurance, and subsequently Evergreen granted him staff privileges. Since 1976, Dr. Backlund has distributed a brochure to his patients informing them that because of his Christian beliefs he does not carry professional liability insurance.

In July 1982, Evergreen began studying a proposal to require all staff physicians to acquire professional liability insurance. After study the Board amended the hospital bylaws on June 28, 1983. The bylaws are expressly subject to amendment and physicians on the staff are "subject to such limitations as are contained in these bylaws."

Dr. Backlund refused to purchase the required insurance. The Board gave notice that failure to comply with the bylaws would result in the suspension of his privileges at Evergreen. Dr. Backlund requested a hearing. In July 1983, the Joint Conference Committee of Evergreen Hospital considered Dr. Backlund's request for an exemption from the amended bylaws and referred his request to the Board. The Board convened a hearing in October 1983, and by mutual agreement postponed the hearing until December. Dr. Backlund testified that he had decided not to carry the professional liability insurance after studying biblical principles. He also testified that he does not carry hospital or life insurance, or use a collection agency for his practice because of his beliefs.

After the December hearing the Board entered its findings of fact and conclusions. Pertinent findings of fact relating to Dr. Backlund's beliefs include:

> 30. That Dr. Backlund professes to have a conviction, based upon his religion, that he should not purchase professional liability insurance coverage.

. . .

32. That Dr. Backlund's conviction with respect to professional liability insurance appears to be a unique position professed to be held solely by himself. . . .

33. That notwithstanding Dr. Backlund's position regarding professional liability insurance coverage, he maintains automobile insurance because it is required by the lease company from which he leases his automobile, and he also maintains homeowner's insurance because his mortgage lender requires it.

. . .

37. That Dr. Backlund appears to be sincere in his beliefs and appears to have held them for sometime.

Pertinent findings of fact relating to Evergreen's interest in requiring physicians to carry professional liability insurance include:

22. [*sic*] That it is recognized that if a physician makes an error or omission which causes harm to a patient, within the Hospital, it is likely that not only the physician, but that the Hospital will be named in any subsequent claim or lawsuit, as a party defendant.

22. That the "deep pocket" theory of litigation is well and commonly known, and it is likely that if a suit or claim were commenced against a physician and the Hospital due to an alleged error or omission that took place at the Hospital, and if through discovery in such a proceeding, it were determined that the physician were uninsured, it is likely that the claimant would attempt to pursue the Hospital for full financial responsibility.

23. That the Hospital, named as a party defendant in a suit with an uninsured physician, may be compelled to exert greater administrative and staff effort

in the preparation for defense of a malpractice claim if the physician involved is uninsured, inasmuch as said physician will not have the assistance of an insurance carrier in the preparation of the defense of his claim.

24. That RCW 4.22.030 relating to contribution amongst joint tortfeasors where the claims are indivisible, may very well place at risk the Hospital for the full amount of any claims by an injured patient even if the majority of the negligence, as would be determined by a trier of facts, were determined to be the negligence of an uninsured physician. . . .

25. That testimony indicates that settlement negotiations with a plaintiff/claimant where the physician is uninsured, are more difficult and potentially more costly to the Hospital than where the physician carries professional liability insurance coverage.

26. That Evergreen Hospital is a participant in the Washington Hospital Liability Insurance Fund . . .

27. That where claims are made against hospitals, the costs of defense and the cost of settlement or payment of said claims is borne by the fund and the participants in the fund, including Evergreen Hospital. While it may be difficult to quantify, there is no question that the more that the fund has to pay in defense of or payment or settlement of claims, the more costly the coverage is to the participants in the fund, including Evergreen Hospital. There is adequate evidence to show that where a physician is uninsured, and the Hospital is named as a party defendant in a claim which arises out of the negligence of a physician in a hospital setting, where the physician fails to maintain professional liability insurance, additional costs and expenses are incurred or may be incurred by the fund, which costs and expenses are then borne by the

participants in the fund, including Evergreen Hospital.

28. That it is prudent that the Board of Commissioners exercise reasonable efforts to protect the assets of the Hospital District . . . and that requiring [professional liability insurance] coverage of physicians practicing at the Hospital is a reasonable and logical extension of the fiduciary duty of the Hospital District.

29. That where a physician is not covered by professional liability insurance, it may cause that physician, as well as the Hospital to practice defensive medicine, in order to protect the assets of the physician and the Hospital. . . . This practice should be avoided because of the extra costs to the patient and the community.

. . .

40. That while it might be difficult to quantify the detriment to the Hospital by a physician not maintaining professional liability insurance coverage, as required by the Bylaws, such detriment or potential thereof clearly exists although shared by all of the hospitals within the Washington Hospital Liability Insurance Fund. That just because it is difficult to quantify the detriment does not mean that the detriment does not exist.

. . .

42. That the Hospital District possesses the authority to require mandatory professional liability insurance coverage of physicians practicing within the Hospital.

43. That if a physician were allowed to practice in contravention of the Hospital District Bylaws requiring the maintenance of professional liability insurance,

> the patients and/or taxpayers of the District may have to bear additional costs and expenses which would otherwise be borne by the physician's professional liability insurance carrier.

After the Board's decision, Dr. Backlund applied for a writ of certiorari asking the Superior Court to review the Board's decision. In its oral decision, the Superior Court held that Dr. Backlund refused to comply with the insurance requirement because of "sincerely held religious beliefs", and that his conduct was constitutionally protected. Further, the court held the Board failed to meet its burden of proving compelling state interests with sufficient evidence. The court also held that the evidence before the Board failed to prove that less restrictive alternatives had been explored. The trial court concluded that the Board's decision was clearly erroneous and Dr. Backlund's privileges at Evergreen should be reinstated.

The Board requested direct review by this court. Later the Board filed with the trial court a motion for clarification of its order. On March 1, 1985, the trial court ruled that the order required Evergreen to reinstate Dr. Backlund's privileges to admit and treat his own patients but that Evergreen was not required to place Dr. Backlund on its emergency room call list.[2] Dr. Backlund has not appealed this order.

It is the province and duty of the judiciary to interpret the law. *Overton v. Economic Assistance Auth.*, 96 Wn.2d 552, 555, 637 P.2d 652 (1981); *Hearst Corp. v. Hoppe*, 90 Wn.2d 123, 130, 580 P.2d 246 (1978). *Franklin Cy. Sheriff's Office v. Sellers*, 97 Wn.2d 317, 646 P.2d 113 (1982), *cert. denied*, 459 U.S. 1106 (1983) stated at page 325:

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[2] Dr. Backlund asserts that his patients consent to his failure to carry malpractice insurance. However, with some exceptions, one may not contract against one's own negligence and it is against public policy to procure a release of liability for malpractice.

> Since issues of law are the responsibility of the judicial branch to resolve, the error of law standard allows the reviewing court to essentially substitute its judgment for that of the administrative body, though substantial weight is accorded the agency's view of the law.

This standard of review applies to our review of the Board and the trial court's application of the constitutional provision involved.

Factual determinations are reviewed under a different standard. Generally, courts are not to retry questions of fact already determined by an administrative body. *Franklin Cy.*, 97 Wn.2d at 324-25; *Thorndike v. Hesperian Orchards, Inc.*, 54 Wn.2d 570, 343 P.2d 183 (1959); *cf. Smith v. Skagit Cy.*, 75 Wn.2d 715, 453 P.2d 832 (1969). Appellate review of administrative decisions is on the record of the administrative tribunal. Although there is evidence to support a finding, the reviewing court can declare a finding to be clearly erroneous when based on the entire evidence in the record if it is left with a definite and firm conviction that a mistake has been committed. *Franklin Cy.*, 97 Wn.2d at 324; *see also Ancheta v. Daly*, 77 Wn.2d 255, 259-60, 461 P.2d 531 (1969); *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 95 L. Ed. 456, 71 S. Ct. 456 (1951). A review of the record does not leave a definite and firm conviction that any mistake has been committed. The Board's findings are not "clearly erroneous." We accept the findings as found by the administrative body. The Board had ample opportunity to assess the credibility of the witnesses and to weigh the evidence.

We turn to the extent to which Dr. Backlund's beliefs and conduct are protected by the free exercise of religion clause of the first amendment to the United States Constitution.[3]

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[3] The parties have not argued persuasively for a different application

To qualify for First Amendment protection individuals must prove only that their religious convictions are sincere and central to their beliefs. The court will not inquire further into the truth or reasonableness of the individual's convictions. As stated by Justice Douglas in *United States v. Ballard,* 322 U.S. 78, 86-87, 88 L. Ed. 1148, 64 S. Ct. 882 (1944):

> [The First Amendment] not only "forestalls compulsion by law of the acceptance of any creed or the practice of any form of worship" but also "safeguards the free exercise of the chosen form of religion." *Cantwell v. Connecticut,* 310 U.S. 296, 303. "Thus the Amendment embraces two concepts,—freedom to believe and freedom to act. The first is absolute but, in the nature of things, the second cannot be." *Id.*, pp. 303-304. Freedom of thought, which includes freedom of religious belief, is basic in a society of free men. *Board of Education v. Barnette,* 319 U.S. 624. It embraces the right to maintain theories of life and of death and of the hereafter which are rank heresy to followers of the orthodox faiths. Heresy trials are foreign to our Constitution. Men may believe what they cannot prove. They may not be put to the proof of their religious doctrines or beliefs. Religious experiences which are as real as life to some may be incomprehensible to others. Yet the fact that they may be beyond the ken of mortals does not mean that they can be made suspect before the law. Many take their gospel from the New Testament. But it would hardly be supposed that they could be tried before a jury charged with the duty of determining whether those teachings contained false representations. The miracles of the New Testament, the Divinity of Christ, life after death, the power of prayer are deep in the

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of the provisions of the First Amendment and Const. art. 1, § 11 (amend. 34) of the state constitution as they pertain to the exercise of religion.

> religious convictions of many. If one could be sent to jail because a jury in a hostile environment found those teachings false, little indeed would be left of religious freedom. The Fathers of the Constitution were not unaware of the varied and extreme views of religious sects, of the violence of disagreement among them, and of the lack of any one religious creed on which all men would agree. They fashioned a charter of government which envisaged the widest possible toleration of conflicting views. Man's relation to his God was made no concern of the state. He was granted the right to worship as he pleased and to answer to no man for the verity of his religious views. The religious views espoused by respondents might seem incredible, if not preposterous, to most people. But if those doctrines are subject to trial before a jury charged with finding their truth or falsity, then the same can be done with the religious beliefs of any sect. When the triers of fact undertake that task, they enter a forbidden domain.

See also State v. Meacham, 93 Wn.2d 735, 740, 612 P.2d 795 (1980); L. Tribe, *American Constitutional Law* § 14-11 (1977). Religious beliefs need not be acceptable, logical, consistent, or comprehensible to others in order to merit First Amendment protection. *Thomas v. Review Bd.*, 450 U.S. 707, 714, 67 L. Ed. 2d 624, 101 S. Ct. 1425 (1981). Courts "have nothing to do with determining the reasonableness of the belief." *State ex rel. Bolling v. Superior Court*, 16 Wn.2d 373, 384, 133 P.2d 803 (1943) (quoting *Barnette v. West Va. Bd. of Educ.*, 47 F. Supp. 251, 253 (S.D.W. Va. 1942), *aff'd*, 319 U.S. 624, 147 A.L.R. 674 (1943)).

The trial court held that Dr. Backlund's beliefs are sincere. Dr. Backlund's beliefs, being sincere, warrant First Amendment protection. However, not all burdens on religion are unconstitutional. *See, e.g., United States v. Lee*,

455 U.S. 252, 71 L. Ed. 2d 127, 102 S. Ct. 1051 (1982); *Prince v. Massachusetts,* 321 U.S. 158, 88 L. Ed. 645, 64 S. Ct. 438 (1944); *Reynolds v. United States,* 98 U.S. 145, 25 L. Ed. 244 (1879). Since Dr. Backlund's beliefs are protected by the free exercise clause of the First Amendment, the burden of proof shifts to the Board to prove that (1) a compelling governmental interest justifies the regulation in question and (2) the regulation is the least restrictive imposition on the *practice* of his belief to satisfy that interest. *United States v. Lee,* 455 U.S. at 257; *State v. Meacham,* 93 Wn.2d at 740.

To justify a substantial infringement of a First Amendment right there must be a compelling governmental interest.

> It is basic that no showing merely of a rational relationship to some colorable state interest would suffice; in this highly sensitive constitutional area, "[o]nly the gravest abuses, endangering paramount interests, give occasion for permissible limitation,". . .

Sherbert v. Verner, 374 U.S. 398, 406, 10 L. Ed. 2d 965, 83 S. Ct. 1790 (1963) (quoting *Thomas v. Collins,* 323 U.S. 516, 530, 89 L.Ed. 430, 65 S.Ct. 315 (1945)). This court has stated the test as follows:

> [Religious] freedom can be restricted "only to prevent grave and immediate danger to interests which the State may lawfully protect." *West Virginia State Board of Education v. Barnette,* 319 U.S. 624, 639, 87 L. Ed. 1628, 63 S. Ct. 1178, 147 A. L. R. 674 (1943). . . . The test must be applied to the facts of each case because, as its author said, "It is a question of proximity and degree."

State ex rel. Holcomb v. Armstrong, 39 Wn.2d 860, 864, 239 P.2d 545 (1952).

However, conduct motivated by religious beliefs may be subject to regulation if that conduct conflicts with the

exercise of the interests of third parties. This concern was articulated by Thomas Jefferson:

> "Believing with you that religion is a matter which lies solely between man and his God, that he owes account to none other for his faith or his worship, that *the legislative powers of government reach actions only, and not opinions,* I contemplate with sovereign reverence that act of the whole American people which declared that their legislature should 'make no law respecting an establishment of religion, or prohibiting the free exercise thereof,' thus building a wall of separation between church and State. Adhering to this expression of the supreme will of the nation in behalf of the rights of conscience, I shall see with sincere satisfaction the progress of those sentiments which tend to restore to man all his natural rights, convinced *he has no natural right in opposition to his social duties.*" (Emphasis added.) 8 Works of Thomas Jefferson, 113.

Braunfeld v. Brown, 366 U.S. 599, 604, 6 L. Ed. 2d 563, 81 S. Ct. 1144 (1961). In *United States v. Lee,* 455 U.S. at 261, we find:

> Congress and the courts have been sensitive to the needs flowing from the Free Exercise Clause, but every person cannot be shielded from all the burdens incident to exercising every aspect of the right to practice religious beliefs. When followers of a particular sect *enter into commercial activity as a matter of choice, the limits they accept on their own conduct as a matter of conscience and faith are not to be superimposed on the statutory schemes which are binding on others in that activity.*

(Italics ours.)

In the area of health and safety, governmental interests often override individual objections to regulations relating

thereto. *See Jacobson v. Massachusetts,* 197 U.S. 11, 49 L. Ed. 643, 25 S. Ct. 358 (1905) (the State can require vaccination though contrary to an individual's religious beliefs); *Jehovah's Witnesses v. King Cy. Hosp.*, 278 F. Supp. 488 (W.D. Wash. 1967) (the State may require blood transfusions for children over objections of parents), *aff'd,* 390 U.S. 598, 20 L. Ed. 2d 158, 88 S. Ct. 1260 (1968); *State ex rel. Holcomb v. Armstrong, supra* (University of Washington requirement that students have an X-ray examination before registration to discover possible tuberculosis infections overrode religious objections thereto); *In re Hamilton,* 657 S.W.2d 425 (Tenn. Ct. App. 1983) (the State may require a 12-year-old girl to submit to cancer treatment over the religious objections of parents).

In many jurisdictions mandatory professional liability insurance requirements are seen as bearing a rational relationship to the health and welfare of the public. The courts have uniformly upheld such requirements, whether in the form of a legislative enactment[4] or hospital rule, because hospitals have the right to take reasonable measures to protect their assets and the patients they serve. *See, e.g., Renforth v. Fayette Mem. Hosp. Ass'n,* 178 Ind. App. 475, 383 N.E.2d 368, 375 (1978), *cert. denied,* 444 U.S. 930 (1979); *Holmes v. Hoemako Hosp.*, 117 Ariz. 403, 573 P.2d 477, 7 A.L.R.4th 1231 (1977); *State ex rel. Schneider v. Liggett,* 223 Kan. 610, 576 P.2d 221, *appeal dismissed,* 439 U.S. 808 (1978); *Jones v. State Bd. of Medicine,* 97 Idaho 859, 555 P.2d 399 (1976), *cert. denied,* 431 U.S. 914 (1977); *Pollock v. Methodist Hosp.*, 392 F. Supp. 393 (E.D. La. 1975). The interests that a hospital has in enacting a mandatory professional liability insurance requirement have been expressed as follows:

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[4] At least two states have enacted legislation requiring health care providers, generally physicians and hospitals, to carry professional liability insurance as a condition of obtaining a license to conduct medical related activities in their states. Kan. Stat. § 40-3402 (1981 & Supp. 1985); 40 Pa. Cons. Stat. Ann. § 1301.701 (Purdon Supp. 1985).

> *In light of the increasing number and amount of personal injury verdicts against doctors and hospitals, it is highly germane to consider a hospital's interest in having its staff doctors insured in an adequate amount and by a reliable carrier.*
>
> *Such coverage protects the vital financial integrity of a hospital. It provides an assured fund to pay a judgment where the doctor is held personally liable.* If by reason of the relationship between a doctor and a hospital, the hospital is held jointly liable with the primary responsible doctor, the hospital would have the right of indemnification against the doctor and the doctor's carrier. Thus, the existence of malpractice insurance covering staff doctors would likely reduce the insurance premium on the hospital's liability coverage. *Lastly, the existence of such coverage protects hospital patients.*

(Footnote omitted. Italics ours.) *Wilkinson v. Madera Comm'ty Hosp.*, 144 Cal. App. 3d 436, 443, 192 Cal. Rptr. 593 (1983).

However, *Rosner v. Penninsuia Hosp. Dist.*, 224 Cal. App. 2d 115, 36 Cal. Rptr. 332 (1964) held that a hospital district could not, absent statutory authority, impose a requirement of minimum malpractice insurance as a condition of medical staff membership. In 1974, the California Legislature adopted statutory authority overruling *Rosner*.[5] *See Wilkinson*, 144 Cal. App. 3d at 441.

Thus health and welfare regulations curtailing the free exercise of religion are justified in order to protect the interests of third parties. With this in mind, we consider whether the Board's findings substantiate the conclusion

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[5] Cal. Health & Safety Code § 1319 (Deering 1982) allows hospitals to require physicians to carry professional liability insurance as a prerequisite to hospital staff membership.

that a compelling governmental interest is involved in the instant case. We find that the findings do.

At the Board hearings to consider Dr. Backlund's request of an exemption to the bylaw requiring him to carry professional liability insurance or face termination of his privileges, the Hospital introduced expert testimony to demonstrate the necessity of the bylaw and to show the substantial interests involved. This testimony included: (1) that the bylaw assured, for the benefit of the Hospital's patients and the community, compensation for patients injured at Evergreen aside from any liability the hospital might have; (2) that enforcement of the bylaw would have a positive impact on the amount of liability expenses that Evergreen would have in malpractice claims; (3) that if the bylaw was not enforced Evergreen would have potentially greater liability exposure because it is more difficult to settle claims prior to trial when an uninsured physician is involved; (4) that when an uninsured physician is involved other defendants having liability insurance become the targets of a medical malpractice suit because they have insurance coverage; and (5) that the insured defendants may pay amounts disproportionately greater than their degree of fault.[6] Other testimony indicated that not requiring professional liability insurance promoted defensive medicine, that is, the ordering of unnecessary treatment for the patient in order to establish documentation in the event

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[6] This concern was very real given then RCW 4.22.030, which read:

> If more than one person is liable to a claimant on an indivisible claim for the same injury,, death or harm, the liability of such person shall be joint and several.

See also Paradise Vly. Hosp. v. Schlossman, 143 Cal. App. 3d 87, 191 Cal. Rptr. 531 (1983) (where one of several joint tortfeasors was solvent tortfeasors shared liability for the shortfall).

The tort reform act (Laws of 1986, ch. 305, § 402) changes the law on joint and several liability. In any event, our consideration is of the risks as *then* contemplated by the Board.

of a lawsuit. The practical effect of a physician's decision not to purchase professional liability insurance is that the physician's hospital and others more or less subsidize the uninsured's practice.

Dr. Backlund contracted with Evergreen for hospital privileges. It is the Board's duty to protect the financial well—being of the hospital. The Board also owes a duty to the hospital's patients, as "hospital[s have] a nondelegable duty owed directly to the patient, regardless of the details of the doctor—hospital relationship." *Pedroza v. Bryant*, 101 Wn.2d 226, 229, 677 P.2d 166 (1984). This duty includes being able to adequately provide compensation to patients injured through the negligence of the hospital and the hospital staff, including those physicians to whom Evergreen has extended privileges.

A significant number of findings of fact are devoted to the need of the Hospital to require its physicians to carry professional liability insurance and these findings amply support the conclusion that there is a compelling governmental interest involved. The Board must also show that the regulation involved is the least restrictive means necessary to satisfy the compelling governmental interest. *Thomas v. Review Bd.*, 450 U.S. at 718. *State v. Meacham*, *supra*, stated that to restrict an individual's exercise of conduct

> the State must have a compelling interest and the restrictive statute must have a "nexus of necessity" with the asserted State interest. If the statute's purpose may be achieved by measures less drastic than restriction of First Amendment rights, the State must utilize such other measures.

(Citations omitted.) *State v. Meacham*, 93 Wn.2d 735, 740, 612 P.2d 795 (1980).

The purpose of the bylaw is to assure that sufficient funds are available to provide for patients who successfully

bring malpractice claims against Evergreen and/or the physicians involved. After study, the Board decided that an insurance requirement best met this concern. Alternatives, such as bonding, also burden the physician. The Board could find no less restrictive alternative that was practical.

Dr. Backlund asserts that the March 1, 1985 court order, which required Evergreen to reinstate his privileges solely to admit and treat his own patients, will serve the purpose of the bylaw by means less drastic than a restriction on his First Amendment rights. We disagree. The trial court order defeats the purposes of the bylaw. Dr. Backlund's practice at Evergreen, even if limited to his own patients, necessarily involves hospital personnel and the use of hospital facilities and services. Thus, compelling government interests, protection of hospital assets, patients and staff are not met by the March 1, 1985 order.

After the Board passed the bylaw, it attempted to negotiate a solution with Dr. Backlund. Dr. Backlund made it clear that he would only be satisfied with an exemption from the bylaw. Dr. Backlund also indicates that he will do whatever he can should a successful malpractice claim be brought against him. This is not sufficient since good intentions do not satisfy judgments. We find that there exists a nexus of necessity between the bylaw and the compelling governmental interest. Further, the facts demonstrate that the bylaw's purpose could not be achieved by any less drastic restriction of Dr. Backlund's First Amendment rights.

Ritter v. Board of Comm'rs, 96 Wn.2d 503, 515, 637 P.2d 940 (1981) held that a public hospital's decision withdrawing a doctor's privileges will be overturned "only if the hospital's action is arbitrary, capricious or discriminatory," *See also Rao v. Board of Cy. Comm'rs*, 80 Wn.2d 695, 698 497 P.2d 591 ("arbitrary, tyrannical or predicated upon a fundamentally wrong basis"), *cert. denied*, 409 U.S. 1017 (1972); *Group Health Coop. v. King Cy. Med. Soc'y*,

39 Wn.2d 586, 669, 237 P.2d 737 (1951). No claim is made that the Board acted in a discriminatory manner. We need only consider whether the Board acted arbitrarily or capriciously.

> Administrative action is not arbitrary or capricious if there are grounds for two or more reasonable opinions and the agency reached its decision honestly and with due consideration of the relevant circumstances. Such action is not arbitrary or capricious merely because an appellate court believes it would have reached a different decision on the same facts. *See, e.g., Barrie v. Kitsap County*, 93 Wn.2d 843, 850, 613 P.2d 1148 (1980). Our scope of review should be especially unobtrusive in this context given the gravity of interests at stake, the inherent difficulty of precisely defining fitness to be a member of a hospital staff, and the judiciary's limited capacity to question competently a hospital administration's discretion in such matters. *See Sosa v. Board of Managers*, 437 F.2d 173, 176–77 (5th Cir. 1971); *Shulman v. Washington Hosp. Center*, 222 F.Supp. 59, 64 (D.D.C. 1963); *Khan v. Suburban Community Hosp.*, 45 Ohio St. 2d 39, 44, 340 N.E.2d 398 (1976). "[S]o long as [initial] staff selections are administered with fairness, geared by a rationale compatible with hospital responsibility, and unencumbered with irrelevant considerations, a court should not interfere." *Sosa*, at 177. There is no reason why judicial review should not be similarly limited when staff privileges are withdrawn.

Ritter, 96 Wn.2d at 515–16. The Board reached the decision to withdraw Dr. Backlund's privileges at Evergreen with due consideration of the relevant circumstances and, in particular, the constitutional issue at stake. The Board did not act in an arbitrary or capricious manner.

Dr. Backlund freely chose to enter into the profession of medicine. Those who enter into a profession as a matter

of choice, necessarily face regulation as to their own conduct and their voluntarily imposed personal limitations cannot override the regulatory schemes which bind others in that activity. Dr. Backlund's practice is open to the public. He enjoys the economic benefits of his practice. However, the practice of orthopedic surgery is a specialty which exposes the practitioner to the risk of large liability claims. Therefore, with these benefits come corresponding burdens, and in this case the need to show financial responsibility in order to meet the liabilities which might result from his practice. Financial irresponsibility presents a substantial risk to his patients. The Board must protect those to whom it is responsible. The Board did so in mandating professional liability insurance. The Board's decision not to grant an exemption is supported by the findings and does not impinge upon Dr. Backlund's right to believe as he chooses, only upon his practice of those beliefs when such practice can be to the detriment of others.

The trial court's judgment is reversed and the decision of the Board reinstated.

DOLLIVER, C.J., and UTTER, BRACHTENBACH, DORE, PEARSON, ANDERSEN, GOODLOE, and DURHAM, JJ., concur.

Supreme Court, U.S.
FILED
APR 10 1987
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CLERK

No. 86-1297

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1986

WILLIAM BACKLUND,

Appellant,

v.

THE BOARD OF COMMISSIONERS OF KING COUNTY HOSPITAL DISTRICT NO. 2,

Appellee.

On Appeal From The Supreme Court of Washington

MOTION OF APPELLEE BOARD OF COMMISSIONERS OF KING COUNTY HOSPITAL DISTRICT NO. 2 TO DISMISS OR AFFIRM

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Questions Presented

A public hospital district in the State of Washington required its physicians as a condition of staff privileges to carry professional liability insurance to protect the District patients and District assets.

One of the District's staff physicians asserted that his right to the free exercise of his religion, as guaranteed under the United States Constitution, entitled him to an exemption from the requirement. A hearing was held and the governing board of the district determined that the physician's federal rights did not entitle him to an exemption, given the fact that he had shown no evidence of how his patients would be compensated in the event his treatment at the hospital caused them to suffer damages for which he was liable and because the assets and patients of the

Hospital District were threatened by his position.

The physician challenged the decision in state court on the ground that the decision of the Board was in error in that his first amendment rights entitled him to an exemption, assigning fault primarily to the findings of fact made by the Board of Commissioners of the Hospital District in rendering its decision.

The Washington Supreme Court unanimously upheld the decision of the Board of Commissioners on the grounds that it was supported by findings of fact that demonstrated a compelling state interest, achievable by no less restrictive alternatives.

The questions presented are:

1. Whether the Washington Supreme Court's denial of the physician's assertion of rights under the free exercise clause is a basis for invoking

this Court's appellate jurisdiction or is the physician limited to seeking review of that decision by a petition for a writ of certiorari?

2. Whether this Court should summarily affirm the decision of the Washington Supreme Court or dismiss the appeal of the physician for lack of jurisdiction or lack of a substantial federal question in that a contrary decision would have (a) potentially left the District's patients without remedy in the event of Dr. Backlund's negligence, and (b) left the assets of the hospital subject to payment for any damages caused by Dr. Backlund if the hospital were adjudged jointly and severally liable for his negligence?

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Motion to Dismiss or Affirm

Pursuant to Rule 16.1, the appellee Board of Commissioners of King County Hospital District No. 2 moves to dismiss the appeal filed on behalf of William Backlund. The motion is grounded in the fact that this case is not within this Court's appellate jurisdiction because the federal question sought to be reviewed (a) was neither timely nor properly raised and (b) does not raise a substantial federal question. Alternatively, the Board moves for the summary affirmance of the decision of the Washington State Supreme Court.[1]

Statutory Provision Involved

In pertinent part, 28 USC §1257 provides:

> Final judgments or decrees rendered by the highest court of the state in

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[1] References to the record will be to the transcript of the hearings (RP), the exhibits introduced before the Board of Commissioners and the Board's Findings, Conclusions and Decision. Other references will be to pleadings in the courts below.

which a decision could be had, may be reviewed by the Supreme Court as follows: . . .

> (2) by appeal, where is drawn in question the validity of the statute
>
> of any state on the ground of its being repugnant to the Constitution Treaties or Law of the United States and the decision is in favor of its validity.
>
> (3) by writ of certiorari . . . where any title, right, privilege or immunity is specially set up or claimed under the Constitution, treaties or statutes, or commission held or authority exercised under, the United States.

Statement of the Case

King County Public Hospital District No. 2 is a municipal corporation organized under Chapter 70.44 of the Revised Code of Washington. The District is governed by its elected Board of Commissioners ("Board"). The District has within its boundaries a portion of the area comprising King County, Washington. Its purpose, as a public hospital district, is to provide health care services for residents

living within the district's boundaries and other patients. The District owns and operates Evergreen General Hospital ("Evergreen"), which is located in Kirkland, Washington, in the greater Seattle area.

Dr. William Backlund became a staff physician at Evergreen in 1974. He does not carry professional liability insurance. When he applied for staff membership privileges at Evergreen, he asked the then superintendent whether the District required its staff physicians to carry such insurance. He was told that such insurance was not then a requirement although the superintendent considered it desirable. In response, Dr. Backlund told the superintendent that he had been informed by his attorney that hospitals themselves carry professional liability insurance. Exhibit C.

Staff members of Evergreen are granted one-year appointments, which may be renewed by the Board. In return, physicians agree to be subject to District Bylaws, which may be amended. Dr. Backlund's privileges were renewed regularly after his initial appointment. Exhibit 23.

In July, 1982, the Joint Conference Committee for Evergreen, which is comprised of hospital administrators, Board commissioners and staff physicians, began studying whether or not it would be prudent for the Hospital District to require staff physicians to carry professional liability insurance as a condition of practicing at the Hospital. Exhibit 2.

Evergreen's chief concern in making the proposal for mandatory insurance for physicians was assuring a fund for the payment of claims to Evergreen's patients

in the event of physician error, regardless of whether the hospital was liable. RP 31.

A second major concern was protecting the hospital's assets where the hospital was jointly and severally liable with the physician, since, by statute, all tort-feasors in the State of Washington are jointly and severally liable to one injured by their misconduct. RCW 4.22.030. (In 1986, the statute was amended by another statute codified at RCW 4.22.070 so that joint and several liability was limited to those occasions where a plaintiff was adjudged not to be comparatively at fault; it is, of course, a situation uncommon in medical malpractice cases for a plaintiff to be found at fault.) Thus, the District, even though, say, 5% liable for the injuries of a plaintiff, would be liable for the full amount of any judgment in the event the

tortfeasor primarily liable could not respond in damages. RP 169.

Third, plaintiffs in medical malpractice cases attempt to include defendants, other than the uninsured physician who is primarily liable, in order to have access to the "deep pocket" insurance coverage of those added defendants. RP 160. As a result, the Hospital's insurance carrier or the Hospital itself if its policy limits were exceeded by a judgment, would likely have to bear the major part of the loss caused by an uninsured physician even if the loss were disproportionate to the amount of negligence the Hospital had committed. RP 167-68. (The Hospital, of course, could expect to be sued whether it was liable or not. RP 162.)

Fourth, cases involving uninsured ("bare") health care providers are more difficult to settle because a doctor

without insurance probably does not have the financial ability to participate fairly in settlement negotiations. RP 165.

Fifth, there was concern over the anxiety among staff members and physicians who were, in effect, compelled to work with bare physicians and were unfairly subject to more liability exposure as a result. RP 118-20.

Sixth, there was concern that bare physicians and those who work with bare physicians would be more likely to practice defensive medicine, that is, medically unnecessary treatment for the purpose of documentation in the event of a malpractice suit. RP 128.

Seventh, there was concern over the long term impact that bare physicians would have on the hospital's liability insurance premiums. RP 147.

The hospital's physicians were asked for their opinions. A majority of the surgical staff voted in favor of the requirement. RP 119. The Executive Committee (which is a committee of physicians concerned with quality assurance at the hospital) voted against immediate adoption, preferring to reconsider the issue in a year. Exhibit 6. The concern expressed by the Executive Committee was whether the decision on insurance should be made by the hospital district or left to the physician and the patient, rather than whether mandatory insurance itself was necessary to protect the public. Exhibit 7; cf. RP 31.

In February of 1983, a draft "discussion" paper was prepared by the administrative staff at the hospital. The staff analyzed the issue from a purely business perspective; the staff did not consider whether there were any

non-business concerns, such as protection of the hospital's patients, which might independently justify the requirement. It was pointed out in the paper that there was one bare physician, Dr. Backlund. Concern was expressed that implementation of the requirement could cause him to move his practice, which would result in a reduction of hospital revenues by over $100,000.00 annually. The staff was also concerned that he might bring a lawsuit over the requirement.

The administrative staff expressed the opinion that the short-term impact of the requirement on the hospital's premiums would not be offset by probable losses. This was so since coverage at that time was through an organization known as the Washington Hospital Liability Insurance Fund (WHLIF). Evergreen's premiums were based on claims against all of the 74 hospitals who were members of the fund

(commonly known as a "community rating") and not on claims against Evergreen alone (that is, an "experience" rating).

The staff recommended that Evergreen request WHLIF to make mandatory malpractice insurance coverage a condition of its insurance coverage for all members of the pool so that the "risk profile of the entire pool [of hospitals]" covered by the insurance, including Evergreen, could be reduced for long-term premium control.

No consensus was reached by the Joint Conference Committee on whether to adopt or endorse the draft paper. The two physicians on the committee abstained from the vote on the ground that this was a business decision outside their "responsibility for quality of care." Exhibit 11.

The Board of Commissioners of the District next considered the matter, and rejected the recommendation in the staff report and its purely business perspective

as short-sighted. The Board instead adopted the mandatory insurance requirement on April 26, 1983.

In doing so, the Board recognized that increased revenues for the Hospital and lower insurance premiums were just two of the District's concern. Another concern was to insure that a fund for District residents was available in the event a physician caused damages in treating a patient on hospital grounds, regardless of the hospital's liability. Exhibit 15.

At the time the Bylaw was passed, Dr. William Backlund had had his staff privileges continuously renewed at Evergreen and was on the call list for the Hospital's emergency room and the general hospital referral list. He had continued not to carry professional liability insurance, which he indicated was in some fashion related to his religious beliefs.

The professional liability insurance requirement became effective on July 1, 1983. On July 5th, over forty physicians, including Dr. Backlund, were notified by letter that their privileges would be suspended for failure to comply with the Bylaw. RP 152. Of those, Dr. Backlund asked for a hearing before the District Joint Conference Committee for the purpose of obtaining an exemption from the requirement. The request for a hearing was granted.

His initial position before the Joint Conference Committee was that there was no reasonable relationship between the requirement and the purpose behind the requirement inasmuch as physician insurance merely "duplicated" coverage the hospital already had. The result, Dr. Backlund argued, was additional cost to the patient without additional coverage. RP 10; RP 59-61.

He testified that because of the practical "secular" benefits of his decision (as well as his desire to "emphasize" various religious principles) he could not in good conscience make any other choice but to continue to not have medical liability insurance. RP 29-31. He indicated that a major benefit was being able to reduce his fees by avoiding the "high policy premium exacted by insurance companies for orthopedic coverage." RP 31. The testimony was that normal coverage for Dr. Backlund's specialty cost between $9,000.00 and $20,000.00 annually. RP 60.

Another benefit was his desire not to participate in what he called the malpractice "easy money" game:

> I don't believe we should be penalized for making honest, human mistakes. I think that it is a totally wrong philosophy in our society.
>
> Sure, if they are grossly negligent, yes, but that rarely occurs nowadays

> in this "malpractice issue." It is a matter of dissatisfied patients or a bad--you know, a poor result or something they don't like, that type of thing.
>
> I think there has to be more trust. I see this as an action of mistrust, that the board of a hospital does not trust the staff of its hospital, at least themselves, and to do high quality of care, which I really believe we do here.

RP 48.

Other reasons he gave for his position were his desire to (1) decrease third-party involvement in his practice, (2) not take cases where he had doubts over his competence, and (3) increase the trust in his relationships with his patients. RP 30-32.

Dr. Backlund was asked about whether he was concerned over the fact that some of his patients, for whatever reason, did not learn of his position on insurance. He said it did not concern him:

> I don't consider it that important. I tell [the patients] that I don't have it. They can go elsewhere if they want. You know, I think you

> folks make a big deal of it. I don't think it is that big a deal.
>
> I think the patient needs to be taken care of. You know, I was thinking about this insurance thing, you know, and why, why, why? Well, never mind.

RP 47.

The evidence at the hearing demonstrated that Dr. Backlund's contention that any insurance he purchased would be "duplicative" was in error. The testimony was undisputed that physicians can be adjudged solely liable for malpractice claims, and that in such circumstances, the hospital's coverage does not provide a remedy for the injured patient. RP 57-58.

At one point, Dr. Backlund was questioned by a staff physician on the Joint Conference Committee concerning Dr. Backlund's unwillingness to provide a fund which would allow him to answer in damages for any negligence he committed:

> [Question by Dr. Wahl] Doesn't that bother you a little bit? That the

> patient does not have any ability to sort of recover damages, let's say, for paraplegia for the next 20 years of his life?
>
> A. No, that doesn't bother me. They need to be taken care of. Tragedies happen. Problems occur in our society and you don't have always to be pointing blames on persons for them and getting money for them.

RP 49.

The testimony presented by the hospital at the hearing indicated that the mandatory insurance requirement was necessary in that it provided a fund to compensate injured patients, and would have a long-term positive impact on the insurance premiums that Evergreen would have to pay. RP 57-58; 35.

In closing argument, Dr. Backlund objected to the hospital's public statements that the decision was made to be "sure that patients will be compensated if they are injured." Dr. Backlund argued that this was a matter that should be left to doctors and their patients. RP 31.

The Joint Conference Committee recommended that the Board of Commissioners grant Dr. Backlund a hearing on whether Dr. Backlund should be granted an exemption from the requirement.

The Board accepted the recommendation. On October 13, 1983, a proposed hearing was canceled so that attorneys for the Hospital and Dr. Backlund could explore the possibility of settling the case. At the October 13th hearing, the Chairman of the Commission directed the Hospital Administrator to inquire into the areas of "possible reconciliation or settlement." There is no evidence of what offers were made in the record. The only evidence is that whatever was proposed as a less restrictive alternative by the Board was rejected by Dr. Backlund; he insisted on a complete exemption. RP 69-73.

Accordingly, no settlement was reached; the hearing was rescheduled for December 8, 1983. This time, Dr. Backlund's primary position was that his assertion of his federal right to freely exercise his religious beliefs justified a "waiver" or exemption from the requirement. RP 198.

Expert testimony at the hearing introduced by the Hospital demonstrated that the Bylaw assured, for the benefit of the community, compensation for patients injured at Evergreen aside from any liability the Hospital might have. RP 151.

The evidence also demonstrated that enforcement of the Bylaw would have a positive impact, which was potentially significant, on the amount of liability exposure the Hospital would have in cases of malpractice claims. RP 144-45; 148-49.

Not only did the evidence show that the requirement protected District patients and assets, but that insured health care providers including Evergreen subsidized the practices of those who were uninsured:

> [T]he practical effect is that the hospital insurance company may well become, for all practical purposes, the insurance carrier for the uninsured physician. . . . The pressure from the plaintiff's attorney representing the injured party is going to be more on the insured party in the case, and I know this case when you have two health care providers, one who is insured and one who isn't, my experience is that the insured health care provider is going to pay the larger part of the expense because it is hard to get blood out of a turnip. (Emphasis supplied.

RP at 165-68.

The evidence demonstrated that this was true because those with insurance become the targets of medical malpractice lawsuits because they have "deep pocket" insurance coverage; they are left paying amounts disproportionately greater than

their degree of fault. RP 160. They also are forced into settling cases where they are without fault because they are exposed to liability greater than their potential comparable liability since they would have no possibility of indemnity from a judgment-proof co-defendant. RP 165-68. This was so since most cases cannot be resolved in a motion for summary judgment. This means that cases either go to trial or settle. RP 163. Because of the great potential exposure in medical malpractice cases, health care providers in the large majority of cases settle even if they are not liable. RP 164. Inevitably, therefore, the insurer for the hospital will act as the insurer for the uninsured physician as well. RP 165.

The evidence also showed that mandatory liability coverage served to decrease defensive medicine, not only by those who would otherwise be uninsured,

but also for those who were required to work with these physicians. Extra unneeded costs caused by defensive medicine were shown to be necessarily passed on to the patients of the hospital. RP 128-29; 137.

Other testimony indicated that insured physicians (and other staff) at the Hospital had expressed anxiety over working with uninsured physicians. RP 103. From a practical point of view, some physicians were compelled to accept Dr. Backlund's decision as it affected them since they were placed in circumstances where they could not, out of concern for the health needs of a patient, refuse to work with Dr. Backlund. The evidence showed, for example, that radiologists, anesthesiologists, and nurses (especially in emergency situations) could not practicably refuse to work with an uninsured physician. RP 115-16;

Memorandum in Submittal of Evergreen Hospital, at 5.

After the hospital presented its case, Dr. Backlund was examined regarding his request for a waiver from the Bylaw. In contrast to his testimony before the Joint Conference Committee, Dr. Backlund did not testify as to any of the non-religiously-based "practical" reasons for his decision. Rather, he indicated that the sole reason for his stand was a religious conviction (which he acknowledged was unique to him and not part of any doctrine of his church) received through "prayerful consideration of the [Bible]." RP 220.

Dr. Backlund was asked how he would compensate patients monetarily in the event he committed an error in his treatment. He indicated he would "do whatever" he could. RP 218. He was also asked if he would consider any

alternatives to insurance such as "bonding" that would demonstrate financial responsibility; Dr. Backlund testified he could think of no alternative that was acceptable. Anything that protected him from his patients' lawsuits, he said, would defeat his "witness to my patients." RP 224-25.

The evidence was that he communicated his beliefs regarding insurance to his patients by making available to them brochures explaining his decision. RP 40. He indicated that it was possible that not all of his patients knew about his position and also admitted that it would be possible for him, while on emergency call, to treat an unconscious patient who would be unable to appreciate his philosophy and accept the risk. RP 47.

Dr. Backlund produced at the hearing the brochure that he had available in his office. The brochure provided that

> I have elected not to be covered by malpractice insurance. Instead my insurance is in the Lord and in your trust in me. As a benefit to you, my fees will be lower accordingly.

The brochure did not mention, however, that there was a potential for patients to suffer damages in the millions of dollars as a result of his treatment as an orthopedic surgeon (RP 177), nor did it reveal the extent of Dr. Backlund's personal capacity to compensate them. The brochure did not explain that the hospital's insurance would not cover Dr. Backlund's patients for negligence when the hospital was not itself negligent (as Dr. Backlund mistakenly believed). RP 57-58.

There was no testimony that all or even a significant majority of his patients had read the brochure or were aware of his position. There was no evidence that those who did read his brochure understood that one of the

consequences of his beliefs was the possibility of catastrophic injury without remedy. See Exhibits F and G. There was no evidence of how minors or those patients who are in pain or who are in the state of an emergency are able to make an informed "choice" over Dr. Backlund's position on insurance. Moreover, Dr. Backlund indicated that he did not consider it "that important" whether his patients knew or did not know he carried insurance. RP 47.

After hearing testimony, the Board on December 12, 1983 determined that enforcing the Bylaw in Dr. Backlund's case was supported by strong reasons of public policy. The Board was willing to give a temporary exemption from the requirement to physicians who, for whatever reason, had difficulty purchasing insurance, but found those circumstances not to be present in Dr. Backlund's case. RP 266.

First, the District determined that the requirement protected its constituents and patients by assuring that an an adequate fund was provided for payment of any claims arising out of errors committed at Evergreen General Hospital, regardless of the District's fault. Commissioner Russ McClintick expressed this concern:

> I feel as representing a public body and the community that we have an obligation to the patients coming into the Hospital and I think that we have a responsibility to the patients if anything accidental were to happen that the Hospital is responsible. I think the only way the Hospital can be responsible is that the people working within the Hospital also have the same responsibility.

RP 265-66. See also RP 252.

Second, the Commissioners determined that rejecting Dr. Backlund's claim of exemption was required in order to fulfill their fiduciary duty to protect the assets of the Hospital. RP 267. They found that were was a significant potential for increased premiums and legal expenses that

would result from Dr. Backlund's lack of insurance. RP 272-74.

The evidence at the hearing had demonstrated that there was a causal relationship between the amount of claims made against Evergreen and its insurance premiums. The more claims, the greater the costs of defense, settlement, and judgments its carrier would have to pay and the larger the subsequent premiums would be (although the costs would be shared by all the member hospitals insured by the Fund). RP 140-47.

Finally, the Board found that it was providing de facto insurance coverage for Dr. Backlund, which was paid for by the taxpayers. RP 268.

The Board unanimously voted to suspend Dr. Backlund's staff privileges at Evergreen General Hospital. The Board entered findings of fact reflecting its position that Dr. Backlund's failure to

purchase insurance would adversely affect the patients of the District's Hospital, and would pose a threat to the Hospital's assets. Findings ¶43.

On December 14, 1983, Dr. Backlund applied for a writ of certiorari from the King County Superior Court. On May 8, 1984, the Superior Court entered a judgment and an order reversing the decision of the Board of Commissioners, primarily on the ground that the finding of facts entered by the Board did not demonstrate a compelling interest to deny Dr. Backlund's assertion of his right to freely exercise his religion under the United States Constitution. The court limited its ruling by not requiring the hospital to reinstate Dr. Backlund to its referral lists.

On direct appeal, the Washington Supreme Court unanimously reversed. Backlund v. Board of Commissioners, 106

Wn.2d 632, 724 P.2d 981 (1986). First, it agreed with the trial court that Dr. Backlund's beliefs were sincere and accordingly warranted First Amendment protection. The court held that to justify infringement of a First Amendment right, the Board had the burden of proving "that (1) a compelling interest justifies the regulation in question and (2) the regulation is the least restrictive imposition on the practice of his beliefs to satisfy that interest." 106 Wn.2d at 641.

The court pointed out that "conduct motivated by religious beliefs may be subject to regulation if that conduct conflicts with the exercise of the interests of third parties." Id. In setting forth this principle, the court relied on United States v. Lee, 455 U.S. 252, 261 (1982), where it was stated:

> Congress and the courts have been sensitive to the needs flowing from

> the Free Exercise Clause, but every person cannot be shielded from all the burdens incident to exercising every aspect of the right to practice religious beliefs. When followers of a particular sect enter into commercial activity as a matter of choice, the limits they accept on their own conduct as a matter of conscience and faith are not to be superimposed on the statutory schemes which are binding on others in that activity. (Emphasis by the Washington Supreme Court.)

106 Wn.3d at 642.

The court noted that in the area of "health and safety," where third parties are impacted, governmental interests often override individual objections to uniform regulations. 106 Wn.2d at 642-4.

In finding the Bylaw supported by compelling governmental interests, the court noted that the testimony before the Board of Commissioners included:

> (1) that the bylaw assured, for the benefit of the Hospital's patients in the community, compensation for patients injured at Evergreen aside from any liability the Hospital might have;
>
> (2) that enforcement of the bylaw would have a positive impact on the

amount of liability expenses that Evergreen would have in malpractice claims;

(3) that if the Bylaw were not enforced, Evergreen would have potentially greater liability exposure because it is more difficult to settle claims prior to trial when an uninsured physician is involved;

(4) that when an uninsured physician is involved, other defendants having liability insurance become the targets of a medical malpractice suit because they have insurance coverage; and

(5) the insured defendants may pay amounts disproportionately greater than their degree of fault.

106 Wn.2d at 644-45.

Other findings indicated that requiring professional liability insurance served to decrease the practice of defensive medicine. 106 Wn.2d at 645. The court also took into account the Board's finding that the practical effect of a physician's decision not to purchase professional liability insurance is that the physician's hospital and others "more

or less subsidize the uninsured's practice." Id. at 645.

The court then expressly held that the Board owed non-delegable duties to its patients, which emcompassed "being able to adequately provide compensation to patients injured through the negligence of the hospital and the hospital staff, including those physicians to whom Evergreen has extended privileges." 106 Wn.2d at 645. (Emphasis supplied.)

The court also examined whether or not the regulation involved was the least restrictive means necessary to satisfy the compelling governmental interest. Here the court mentioned that despite the Hospital's attempt to negotiate a solution with Dr. Backlund, he "made it clear that he would only be satisfied with an exemption from the bylaw." Id. at 646.

Further, the court underscored that Dr. Backlund did not provide any assurance

he could respond in damages to an injured patient, but only that he would "do what he could" in that event. The court was understandably unpersuaded, "since good intentions do not satisfy judgments." Id. at 646. Dr. Backlund perfected his "appeal" to this Court on February 5, 1987.

Law and Argument

A. The Court should treat this case as a petition for writ of certiorari inasmuch as the appeal was improvidently taken.

This Court has under 28 U.S.C. §1257(2) appellate jurisdiction only when the "validity of a state statute is drawn into question" as being "repugnant to the constitution, treaties or law of the United States and the decision is in favor of its validity." In contrast, review of a state court decision shall be by certiorari by this Court "where any title,

right, privilege, or immunity is specially set up or claimed under the constitution" 28 U.S.C. §1257(3). At all times during this litigation, Dr. Backlund asserted that he was entitled to an exemption or waiver from the Bylaw on the ground that his free exercise rights prevented application of the Bylaw to him. See RP 55; Physician's Memorandum before the Joint Conference Committee at 8 (issue was whether Dr. Backlund's religious belief was overridden by public need). He has never challenged the validity of the law on First Amendment grounds. RP 10. At the hearing before the Board, Dr. Backlund's attorney claimed a "waiver" was "justified because [the bylaw] requires him to do something that is contrary to his [religious] conviction." RP 198; see also RP 87 and 94. Dr. Backlund summarized his position before the Washington Supreme Court as a request for

an "exemption from [the Bylaw]" because of his assertion of first amendment rights. Respondent's brief to the Washington Supreme Court at 5-6. The adverse decisions by the Board of Commissioners and the Washington State Supreme Court were expressly denials of his assertion of federal rights rather than a validation of a state statute. As the Washington Supreme Court stated:

> The Board's decision not to grant an exemption is supported by the findings and does not impinge upon Dr. Backlund's right to believe as he chooses, only upon his practice of those beliefs when such practice can be to the detriment of others.

106 Wn.2d at 648.

Where the "appellant" has only raised federally protected rights as a shield against enforcement of a legislative enactment, this Court has held that review in the Supreme Court must be by a petition for writ of certiorari. See Mergenthaler Linotype Company v. Davis, 251 U.S. 256

259 (1920). See also Richmond Newspapers, Inc. v. Virginia, 448 U.S. 555, 562-63 n. 4 (1979).

Moreover, Dr. Backlund's objections in both the King County Superior Court and the Washington State Supreme Court related primarily to the findings of fact made by the Commissioners rather than to the validity of the provisions of the State statute. Dr. Backlund argued in both courts that the findings demonstrated only "speculative" harm and, thus, did not support the decision of the Board. Physician's memorandum of authorities upon review to the King County Superior Court at 31-35. Respondent's brief to the Washington Supreme Court at 39-50. Constitutional objections relating primarily to the propriety of findings by a state agency rather than to the validity of the provisions of a state statute are reviewable only by certiorari and not by

appeal. See Lerner v. Casey, 357 U.S. 468, 473 (1958).

In any event, Rule 15.1(g) requires the appellant or petitioner to set forth in the statement of the case pertinent quotations of specific portions of the record where the questions sought to be reviewed were raised and the manner in which they were passed on. Dr. Backlund has failed to comply with this rule and this Court should summarily treat the case as an appeal improvidently taken. This is so since the appellee will have no opportunity to rebut any contention Dr. Backlund raises hereafter on this issue.

B. The questions presented by the appeal are not substantial.

1. The court below fully considered and correctly decided the issues raised.

The decision by the Washington State Supreme Court was arrived at by careful

application of the law established by this Court. The decision was a sound one that recognized that the District is in the unique position of being the only entity that can protect its patients that suffer damages as a result of Dr. Backlund's treatment, where he alone is adjudged to be negligent.

The court's decision therefore was a holding that Dr. Backlund's belief must defer to that possibility. Moreover, the additional concerns the Hospital had with regard to jeopardizing the assets of the Hospital, reducing its premiums for insurance coverage, the practicing of defensive medicine and reducing the anxiety of those staff members compelled to work with Dr. Backlund, added to the weight of the interests of the District had in refusing to grant Dr. Backlund an exemption.

The Court recognized that those who enter into a commercial activity as a matter of choice, may not impose their religious beliefs on a regulatory scheme that is binding on all others. In so holding the court faithfully applied the doctrine in United States v. Lee, 455 U.S. 252 (1982); see also Bob Jones University v. United States, 461 U.S. 574, 602-604 (1983).

2. The decision is consistent with the jurisdictions of other state and federal courts and the decisions of this Court.

Dr. Backlund has failed to identify the decision of any other state or federal court that is in conflict with the decision of the Washington State Supreme Court. The appellee's review of the law reveals that the Washington State Supreme Court's decision is consistent with all other state jurisdictions and the decisions of this Court.

While there is no case appellee is familiar with in which a mandatory insurance requirement has been challenged on religious grounds, all jurisdictions faced with challenges to mandatory medical malpractice insurance as a condition of hospital staff privileges have denied the challenges. See, e.g., Holmes v. Hoemako Hospital, 117 Ariz. 403, 573 P.2d 477 (1977); State ex rel. Schneider v. Liggett, 223 Kan. 610, 576 P.2d 221, 227, appeal dismissed, 439 U.S. 808 (1978). Cf. Cal. Health and Safety Code, §1319 (West 1979) (reversing by statute a decision in favor of a physician in Rosner v. Pennisula Hospital District, 224 Cal.App. 2d 115, 36 Cal.Rptr. 332 (1964).

Moreover, the Washington Supreme Court's decision is consistent with the decisions in other state courts denying challenges on religious grounds to commercial regulations binding on all

others in the field. See, e.g., Cooper v. Eugene School District, 301 Or. 358, 723 P.2d 298 (1986), appeal dismissed ___ U.S. ___ 1987) (school law barring teachers from wearing religious dress); Minnesota v. The Sports and Health Club, Inc., 370 N.W.2d 844 (Minn. 1985), appeal dismissed, ___ U.S. ___, 106 S.Ct. 3315 (1986) (anti-discrimination laws); State ex rel. Douglas v. Faith Baptist Church, 207 Neb. 802, 301 N.W. 2d 571, appeal dismissed, 454 U.S. 803 (1981) (defendants claimed that their religious convictions prevented them from complying with state school laws).

3. Because the issue presented to this Court is primarily factual and the facts are unique to this case, this Court's resolution of the case will not provide guidance to other courts.

The argument presented to this Court by the appellant is that the Washington

Supreme Court incorrectly determined that the facts as established by the Board of Commissioners represented a compelling interest. There is no serious question that the Washington State Supreme Court in resolving this dispute applied the proper rules of law to the facts. In reviewing this decision, this Court would be merely rehearing the factual record, and not establishing law that will more clearly guide lower state courts in resolving disputes over the free exercise of religion.

As discussed above, there is no case that appellee's counsel has been able to find where a person has challenged a mandatory insurance requirement on the basis of religious beliefs or on the basis of any other "fundamental right." However, because all states have mandatory insurance requirements in a variety of areas, plenary review would have

wide-ranging implications. To the extent the issue is significant, it makes more sense to allow the general question to be decided by lower courts first so that the complexity of the issue and its consequences can be fully appreciated.

Further, the Court's decision, if it accepted review, would not resolve this case. Dr. Backlund's primary argument is that because Evergreen's insurance is community rated rather than experience rated, its premiums would not be significantly affected if it were drawn into a lawsuit as a result of Dr. Backlund's negligence. Dr. Backlund argues from this that the Hospital's interests are not compelling. After the record closed, however, the Hospital's insurance coverage was placed with another carrier, Lloyd's of London, with premiums based on an experience rating.[2]

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[2]The Washington Rules of Appellate Procedure only permit supplementation of

4. Dr. Backlund's arguments in favor of this Court noting probable jurisdiction are not persuasive.

Dr. Backlund's principal argument is that the Board's interest in providing a fund to compensate patients for negligence of Dr. Backlund regardless of anyone else's liability is "paternalistic."[3]

2(continued) the record with additional evidence when that "additional evidence would probably change the decision being reviewed." RAP 9.11. Obviously, the Washington Supreme Court would not be able to make such a finding in this case.

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[3]Dr. Backlund has also asserted that the Hospital District's claim that one of its interests in enacting the Bylaw was to provide a fund to compensate injured patients was not "raised" as a defense of the bylaw in its hearing. In fact, it was raised by the commissioners. Dr. Backlund himself, before the Joint Conference Committee, objected to the Hospital's public announcement that the decision to impose the requirement was made to "be sure the patients will be compensated if they are injured." RP 31. See also RP 265-66.

This is closely related to his contention that the case implicates the privacy and associational rights of Dr. Backlund's patients. His argument presumes that his patients have freely chosen to be treated by him and that this decision should not be interfered with by the Hospital District.

First, there is no evidence in the court below that there was anything approaching informed consent on the part of the patients. The evidence in the record is that the way in which Dr. Backlund communicated his beliefs with regard to insurance was through his brochure. Other evidence was that two of his patients claimed by affidavit that they had read the brochure.

Regardless of whether patients actually read the brochure, it failed to disclose the catastrophic risk that the patients were assuming by being treated by

Dr. Backlund. The brochure did not tell the patients that they would not be covered by the insurance of others if Dr. Backlund was alone adjudged to be liable, nor did it disclose the extent of Dr. Backlund's ability personally to satisfy judgments against him. Furthermore, there are serious doubts as to whether patients in emergency situations (or simply cases where considerable pain is involved) or minor patients can meaningfully "consent" to the terms of the brochure.

Even assuming there was informed consent, however, legal "paternalism" is a well recognized function of the state. See Walters v. National Association of Radiation Survivors, ___ U.S. ___, 105 S.Ct. 3180, 3190 (1985) ("paternalism . . . a legitimate legisative goal."); Jacobson v. Massachussets, 197 U.S. 11 (1905) (mandatory vaccinations upheld despite violation of the individual's

religious beliefs). Such "paternalism" protects the public from unrecognized dangers, often when one party is particularly vulnerable to another party's influence or bargaining power. An illustration is the principle of law that prevents a health care provider from attempting to contractually limit liability for negligence. See Meiman v. Rehabilitation Center, Inc., 444 S.W.2d 78 (Ky. 1969). Cf. Shorter v. Drury, 103 Wn.2d 645, 695 P.2d 116 (1985). Dr. Backlund's argument would logically allow him to require patients to agree in advance not to sue him--he could claim that such suits hindered the trusting relationships necessary to his religiously inspired views of proper medical care. RP 29-34.

This is not a case where an entire sect has a tradition of accepting the risks of particular conduct, and providing

a remedy for the harm that results from that conduct. Compare Wisconsin v. Yoder, 406 U.S. 205 (1972).

As to the claim of injury to privacy and associational rights, there is no evidence in the record that Dr. Backlund's patients shared his beliefs or would refuse to be treated by him if he obtained insurance; rather, the evidence is that two of his patients (who, because they testified by affidavit, could not be cross-examined) were willing to accept his beliefs.[4]

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[4]There is no evidence in the record (nor does appellant cite to such evidence) that any patient has claimed that his right of privacy or association was violated by the Board's action. No patient has brought a lawsuit with regard to such claim. Dr. Backlund never alleged standing to assert those rights for the patients either before the Board or in his petition for writ of certiorari before the King County Superior Court. Accordingly, since this "issue" was never argued or supported by any evidence in the courts and the administrative board below, this court should strike the issue from the

The concerns of the District, further, are not satisfied by Dr. Backlund's newly discovered "less restrictive alternatives." Initially, it is submitted that Dr. Backlund's claim of less restrictive alternatives should not be considered by this Court. The record does not reveal the nature of the confidential settlement discussions that explored alternatives to Dr. Backlund's suspension. Dr. Backlund's recital of alternatives, moreover, is at opposition with his statements on the record that he sought only an exemption or waiver and could conceive of no alternatives that would be acceptable to him.

In any case, the alternatives suggested do not address the real concerns of the District. For example, Dr. Backlund proposes to provide an extra million

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4 (continued) jurisdictional statement. Alternatively, the claim should be dismissed summarily.

dollars worth of insurance coverage for the Hospital. This alternative does not provide a remedy for his injured patients if he is adjudged solely liable or address the other concerns of the District concerning deep-pocket liability, defensive medicine, difficulties in settling cases with bare co-defendants, staff anxiety and other matters.

Dr. Backlund also proposes (for the first time in this case) to pay any premium increases for the Hospital caused by his negligence. This alternative assumes that the amount of the increase attributable to his negligence could be segregated (an unlikely possibility that is not demonstrated on this record). More important, there is no indication how Dr. Backlund could insure that a fund would be available to pay for the increases which are indefinite as to amount and length of time.

Dr. Backlund also argues that the Hospital's duty to provide for a fund to compensate injured patients is somehow suspect and does not rise to the level of being compelling because it was created by the Washington Supreme Court and not by the State Legislature. Dr. Backlund argues "[t]o be sure, if the state legislature had imposed the requirement, as an expression of its general power to further the welfare of its citizens, the [Washington] Supreme Court would be on more solid ground." Jurisdictional Statement at 27.

There is no authority with which appellee is familiar that creates a hierarchy of duties based on whether a duty is created by a court or a legislature, as suggested by the appellant. The type of duty imposed by the Washington court here is hardly different in kind from the range of

responsibilities placed on public and private parties by common law courts. Regardless, the appellant fails to address the fact that the Washington state legislature delegated its authority to create such a duty, by enacting enabling legislation for a public hospital districts, to the Board of Commissioners in this case.

Dr. Backlund further argues that this case presents substantial new doctrinal questions to this Court. For example, he contends that it implicates whether the doctrine of Sherbert v. Verner, 374 U.S. 398 (1963), should apply to the denial of public facilities. However, the Washington Supreme Court decided that the Sherbert doctrine did apply, but that the interests of the District overrode Dr. Backlund's free exercise rights--a factual determination. See 106 Wn.2d at 641.

Dr. Backlund suggests that the issue of whether the fact that "third parties are affected necessarily establishes that a compelling state interest exists" would be a doctrinally substantial question. But it is well established that a compelling interest may be established because of an adverse effect on third parties. See e.g., United States v. Lee, 455 U.S. 252 (1982). Whether the adverse effect will in a particular case justify the government in restricting the exercise of a religious belief depends upon the degree of danger to the third party, which, again, is a factual issue.

Finally, Dr. Backlund maintains that the law of joint and several liability has changed in Washington since the record closed and that the state now follows a rule of comparative liability for joint tortfeasors. Jurisdictional statement at 24. Dr. Backlund's characterization of

state law on this point requires clarification. In 1986, the Washington statute providing for joint and several liability was amended so that it would not apply in those circumstances where comparative fault on the part of the plaintiff was established. See RCW 4.22.030; 4.22.070. It is the rare case, of course, where a medical malpractice plaintiff is adjudged to be comparatively at fault.

Dr. Backlund also argues that the Commissioners relied on "speculative" evidence in reaching their decision. He incorrectly assumes that positions based on nonquantifiable evidence are supported only by speculation. As United States v. Lee, 455 U.S. 252 (1982) demonstrates, a compelling state interest may be supported by factual although nonquantifiable evidence. In Lee, an Amish employer objected to the withholding of social

security tax for his employees, asserting that such tax conflicted with his right to freely exercise his religion. Rejecting the employer's argument, this court stressed that "tax system could not function if denominations were allowed to challenge the tax system because tax payments were spent in a manner that violates their religious belief." There was no quantification of the probability of the harm to the tax system. Instead, the conclusion was based on reasonable assumptions about the likely consequences of accepting the claim for exemption.

In the present case the Board of Commissioners relied on factual evidence in reaching its decision. Despite questioning from the Board, Dr. Backlund would provide no evidence of how he could compensate patients for injuries suffered, for which he alone was liable. Perhaps the Board did not--or could not--assign a

precise probability to this consequence but this does not mean the danger is conjectural. The other harms--such as the causing of staff anxiety, defensive medicine, and the likelihood of the hospital's assets being adversely affected--may also be difficult or impossible to quantify, but concern over these damages was based on the direct experiences of qualified observers.

Conclusion

This case was correctly decided by the Washington Supreme Court. The Board's interests are indeed compelling. Moreover, reversal of the Board of Commissioners would not permit Dr. Backlund to practice without insurance. It could only permit him to practice with the insurance purchased by others, except in those circumstances where he is adjudged solely liable for injury to one of his patients. And, even then, the

reality is that the hospital and other physicians would, as a practical matter, be insuring Dr. Backlund's defense.

Regardless of whether the Washington Supreme Court's unanimous decision was incorrect, the case itself presents no novel issues of general applicability. Accordingly, this court should decline plenary review.

Respectfully submitted,

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